Editorial

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Just societies: A new vision for health equity in the Americas after COVID-19

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The significant challenges to equity in health in the Region of the Americas, as detailed in the report of the Pan American Health Organization Independent Commission on Equity and Health Inequalities in the Americas (1), gave original impetus to this Special Issue on Equity in Health by the *Pan American Journal of Public Health*. The report, *Just Societies: Health Equity and Dignified Lives*, analyzed a vast body of evidence that indicated the overwhelming inequalities in the Region that relate to three factors: structural drivers, conditions of daily life, and governance for health equity (taking action).

Highlighting the continued realities of the interrelationship between social and health inequities in the Americas is by no means new (2). However, since early 2020 this interrelationship has been further exposed and exacerbated by the unprecedented COVID-19 pandemic, which is testing governments, communities, economies, and individuals in ways previously unimagined in their scope and intensity (3). The crisis is exposing underlying inequalities in health and the cost of inaction to address this long-standing social injustice, and the COVID-19 response is even reversing improvements in social and health indicators made in the last two decades (3, 4).

The pandemic is throwing into sharp relief existing inequalities in both its direct and indirect effects. Emerging data from different corners of the world reveals the social gradient for COVID-19 mortality to follow a similar trajectory to that of the social gradient in all-cause mortality. Key data demonstrate inequities in COVID-19 cases, underlying conditions, and mortality, from countries as different as the United States and Brazil. Household survey data analysis from Brazil included in this special issue shows that socioeconomic and ethnic group inequalities are associated with risk of infection, with the highest prevalence of cases among indigenous and Afro-Brazilians compared to others (5). This is similar to the case of the United States, where deprivation and Afrodescendance correlates strongly with mortality (6). On the other hand, the equitable response to the pandemic in Cuba, included in this issue, reflects the advantage of concerted national responses built on strong primary health care systems (7). This demonstrates that, without concerted political will and dedicated efforts, a country's overall wealth and state of economic growth do not by themselves provide the answer to addressing inequities in health. The case study from Costa Rica, in this issue, reinforces the point that, above a threshold, economic fortunes are not the key to health success (8).

The direct effects of COVID-19, however, are not the end of the story. The indirect effects are also exacerbating existing health inequalities, as access to essential health services is threatened in the context of overwhelmed health systems (4). Decreased rates of immunization have already been noted, despite previous significant efforts to address inequities (9). Non-communicable diseases management is also facing challenges. The latter is of especial significance to groups occupying lower socio-economic status who face profound inequities in access to money and resources that directly affect the conditions of their daily lives, and those facing discrimination, such as indigenous and populations of African descent, who already faced risks with regards to NCDs (10). Concern over access to reproductive health services has also been expressed (4, 11, 12), and services for survivors of violence against women are threatened (11, 13, 14).

The indirect effects of COVID-19 beyond health are equally as disturbing for the possibilities of maintaining and accelerating gains in population health with an equity lens into the future (3). The necessary containment measures have particularly impacted upon the livelihoods of populations in situations of vulnerability. Those in higher socioeconomic positions are sheltered from the most severe repercussions of stay at home measures, being able to work from home and living in less crowded conditions. However, most of those engaged in employment with unstable, informal conditions without social

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protection (many of whom are low-paid essential workers) do not have this luxury. For them, adhering to public health measures is exceptionally challenging and overcrowded conditions increase risk of infection (as well as, for a significant number of women and girls, of the 'shadow pandemic' of violence against women) (11) as does their need to leave their homes to generate income, tackle food insecurity, and meet their family's basic needs. Loss of employment and income affects their wellbeing and the social determinants of their health for years to come, as pre-existing inequities are deepened and their social conditions worsened (15). Diverse groups are experiencing COVID-19 itself, as well as the repercussions of its containment measures, in ways specific to their realities and cultures in ways that are only beginning to be captured. These difficulties not only hamper effective national and local responses but also demonstrate the severity of risks to lives, even while communities and individuals, in the absence of other protective mechanisms, such as adequate social protection and universal health, are fostering their own forms of resilience (10).

As with our understanding of the COVID-19 virus itself, the data and analysis to show the full extent of inequalities in COVID-19 and its impacts are still developing. As we grapple with understanding its full equity dimensions, a light has also been shone on another inequity in health – the gaps in our knowledge and thus our ability to hold governments to account for health equity because of a lack of sufficient disaggregated data. This issue includes a proposal for an approach that would retrieve more information that could inform health equity oriented policies (16).

This special issue reflects that the pandemic has, therefore, added yet greater urgency to the need for heightened multi-sectorial action on equity in health (17), including fully implementing the Commission recommendations. This action is two-fold. On the one hand, it involves a broad spectrum of commitments from within the health sector, including primary health care and social protection in health to ensure both universal coverage and access within a proportionate universalism framework (18). On the other, it involves commitments to work beyond the health sector to address the social determinants of health, including action to improve the conditions in which people are born, grow, live, work and age, enacting comprehensive social protection and welfare system based upon solidarity, and realizing the redistributive potential of social spending to address the social determinants of health—as has also been addressed by the United Nations Secretary General (19).

New, deeper, approaches to health equity are also required. We find ourselves in one of perhaps the most significant and potentially sea change moments of our time for highlighting and acting upon health inequities in a sustainable and transformative way. Attention to inequities in health not only resonates with the realities of current COVID-19 inequities but also with political phenomena, such as the Black Lives Matters movement. As well as continuing to analyze and act upon the severe inequities in access to money and resources and in the living conditions that affect health, these have demonstrated that the complexity of addressing health inequities also requires different analyses and a renovated focus on structural drivers. The Commission findings and recommendations had already opened the door to these considerations with the explicit recognition of the need to reverse the health equity impacts of ongoing colonialism and structural racism, as well as gender-based discrimination. We now need to go further in developing an operational focus that goes beyond the targeted 'vulnerability' lens to specific population groups to one that truly addresses underlying structural drivers, in addition to other social and economic factors affecting access to resources for health, including explicit action against gender and ethnic discrimination and to end racism (20).

The variety of analysis that are expressed in this special issue's diverse articles reflect this need for multiple consolidating approaches to health equity. Their focus ranges from the need for an equity focus in national health plans (21), in public health infrastructure (22), and in access to technology (23); the urgency of action on the social determinants of health as well as on structural drivers, including gender inequality and structural racism (24, 25); and intercultural approaches and traditional medicine (26). They also demonstrate the importance of accountability mechanisms, such as the roles of civil society (27) and collaborative research (17, 28).

Using the rich wealth of such analysis, we currently have an unprecedented opportunity to rebuild better and to create a more inclusive and equitable reality out of the devastation of COVID-19, one that grapples with these complexities with renewed commitment and purpose. Several elements will be crucial in our roadmap towards this 'new normal'.

We must, for example, address structural drivers through human rights approaches and, in particular, through inclusive governance, since where 'institutions are not accountable, transparent, participatory, or coherent, we will be far less likely to see the policy change necessary to deliver health equity' (29). This requires going beyond community and civil society 'participation' towards an inclusive governance model that readjusts inequities in power and voice to address structural drivers, such as, amongst others, systemic racism and institutional discrimination. Diverse traditionally excluded groups must be made equal partners in governance, leadership, and decision making in a renovated approach to democracy (1). The Commission's third general recommendation and its sub-recommendation related to including people of African descent and indigenous communities in law-making, service design and provision, and other decisions that affect their lives lays the groundwork for this radical new vision. Indeed, it is more pertinent than ever given the realities of racial discrimination and ethnic disparities laid bare by COVID-19 (10) and the Black Lives Matter movement. However, this approach is not unique to the perspective of ethnic and racial exclusion and discrimination and can be extended to inclusion and addressing discrimination from other perspectives. These include, amongst others, gender (with reference to women and girls' empowerment, as well as the discrimination faced by LGBT groups), those living in situations of socio-economic vulnerability, migrant populations (30), and/or those affected by other forms of discrimination, for example, those living with disabilities.

Inclusive governance also encompasses accountability for action and results. Within the framework of the Commission recommendation on making health equity a key indicator of societal development and establishing mechanisms of accountability, generating and reporting of disaggregated data is fundamental. In line with the first essential public health function—surveillance of population health and well-being (31)—and the first impact indicator of PAHO's current Strategic Plan (32), 'Reduction of within-country health inequalities',

institutions need to invest in the capacity to not only sporadically report health inequalities but to institutionalize monitoring within the health situation analysis. In this way, addressing inequities can be normalized as a parameter of success. Furthermore, data needs to be used to inform policy action to increase its potential for impact. We need more research on the specifics of what works, as well as to make better use of the evidence we already have. Transparency also forms the basis of inclusive and effective governance. Evidence should be made publicly available, including on how evidence on inequities is being used in policy making and monitoring and, perhaps even more importantly, where the gaps are.

A new equitable vision for the post-COVID-19 world also requires reinforcing other ways of working 'differently'. It necessitates cooperation, collaboration, and inclusive governance at different levels. As well as working to address equity within its own direct significant sphere of societal influence, namely health policy, programs and services, the health sector needs to commit to intersectoral action with other government partners on the social determinants of health, based upon the understanding of their significance to reducing health inequities. As evidenced in the Health Equity Network for the Americas (HENA) (17) and the Movement for Sustainable Health Equity discussed in this issue, collaboration between communities and actors at all levels will heighten potential for impact upon health inequities into the future.

And, finally, but no less importantly in today's increasingly polarized world, global and local cooperation between and within countries to advance a more equitable model for health and development is a moral imperative. This pandemic has, without doubt, worsened fractures and created new ones in our fragile social structure, but it has also given us a space and hopefully the will to repair them. If COVID-19 allows for the creation of a renovated development model based upon 'a new social compact' with shared commitments and cooperation between countries and communities, there is a greater chance than ever before to redress past injustices and achieve equity in health in the Americas.

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