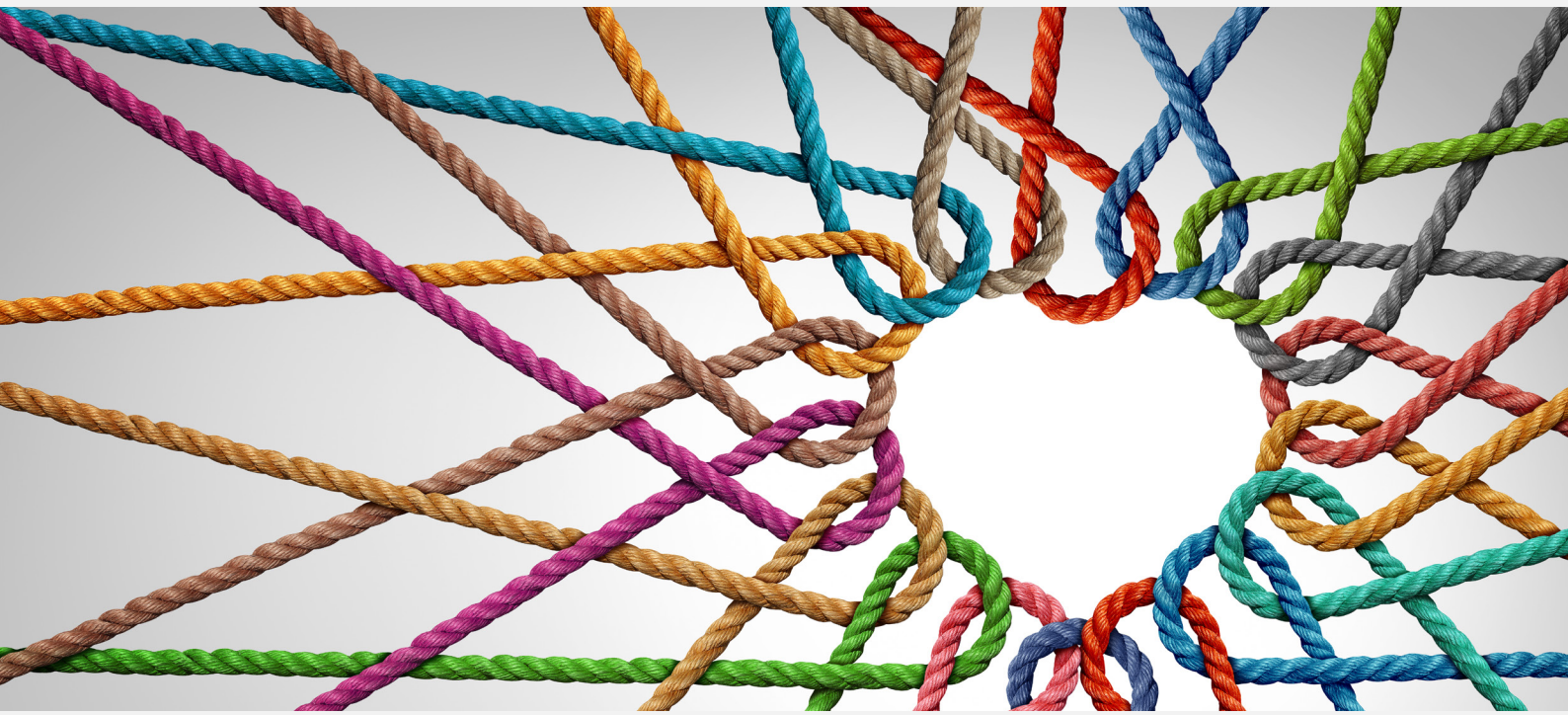
ECONOMIST IMPACT

# Achieving health equity: a roadmap to eliminating disparities

## Lessons at the intersection of HIV and other STIs, mental health and covid-19 in the US and UK



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# Executive summary

## Background: Health disparities cost us all

Health disparities are avoidable and unfair, and they should not exist. Despite this, they persist even in the most advanced health systems, impacting on people's health, life expectancy and access to healthcare. The differences that create health disparity arise from a variety of factors, such as a person's economic situation or where they live, as well as individual characteristics such as race, ethnicity, sexuality and gender. While each of these can yield disparities on their own, they also overlap significantly, deepening health inequity for vast numbers of people.

**"Covid-19 has shone a bright light on our own society's failings."**

Anthony Fauci
Chief Medical Advisor to
US President Joe Biden

The covid-19 pandemic has further exposed existing health disparities. Groups already experiencing poorer health outcomes have been less able to protect themselves from exposure to covid-19, experienced more acute illness, been more likely to die from the disease, or have endured poorer quality of life and mental health than others. "Covid-19," said Anthony Fauci in May 2021, "has shone a bright light on our own society's failings."

Disparities have a real, quantifiable impact on individuals and societies, yet they stubbornly persist. Many agree that it is important to address health disparities and know what needs to happen in the abstract; what is missing is cohesive action.

## Our approach

In this report, Economist Impact seeks to go beyond discussing health disparities, instead proposing clear, achievable ways to address them. Focusing on covid-19, HIV and STIs, and mental health, we explore the opportunities that eliminating health disparities in the UK and US over the next two decades—an ambitious, but manageable milestone—could create.

Informed by a literature review and expert interviews, we assess what has been done historically and what is currently being done. From there, we imagine what the future could look like, as well as identifying the steps that will need to be taken to achieve the elimination of health inequity in specific areas (an approach known as "foresight analysis"). To make our proposals actionable, we identify a range of relevant stakeholders and assign them specific actions. These are the three key scenarios that we identify:

### Covid-19 becomes a blueprint for equitable health preparedness and protection

In the year 2040, covid-19 is recognised as a key historical exemplar of how disparities in outcomes can be bridged.

### The global HIV epidemic comes to an end

The international community succeeds in eliminating HIV over the next 20 years. While prevention efforts remain in place, resources for treatment shift to other priorities, raising health access, quality and trust among vulnerable populations.

### Mental health becomes the connector for bridging the gaps between public health and healthcare

To achieve equitable access to mental health services by 2040, health systems, the justice system and other areas continue to drive better integration of mental health into primary care and create services that are more sensitive to the needs of diverse populations.

## Step 1: Defining the vision

To make an actionable plan, we began by identifying some of the main factors that create health disparities. We then identified the outcomes that would define our vision of health equity, as well as identifying the broad steps needed to realise this vision (see Table 1).

Table 1: The journey and the vision: achieving health equity

| The current landscape: | The road to health equity: | Envisioning health equity: |
|---|---|---|
| Acute, reactive care that incentivises the status quo | Restructure health systems to incentivise prevention for both physical and mental health | Expanded access to equitable public health and primary care services |
| Disparities lead to resource-intensive care and wasted investment | Reimagine investment beyond the upfront cost | Increased fiscal space for other priorities |
| Siloes among stakeholders | Focus on individuals' capability, opportunity and motivation | A shared vision for a collaborative and systems-oriented approach |
| An innovation gap | Improve our understanding of how individuals receive and act on information | Mapping a new, more advanced stakeholder landscape which can promote innovation |

## Step 2: Turning vision into action: stakeholder actions needed to achieve health equity

The final part of defining our roadmap to health equity involved defining seven stakeholders who most directly influence health disparities and identifying a set of actions for each stakeholder group. These actions are wide ranging: for example, we ask healthcare institutions to make their data collection methods more robust; suggest that industry implements key performance indicators linked to health equity; and propose that community organisations more effectively harness social media. These actions, which are laid out in full in the report itself, are practical, grounded in evidence and achievable. One thing that we do not do is make demands of the people who rely on health services; it is not the responsibility of ordinary people to fix the problems of a system that exists to serve them.

Figure 1: The health equity stakeholder ecosystem


Source: Economist Impact

## Less talk, more action: health equity depends on a clearly defined, inclusive vision

This report is not the first to make a clear case for the pursuit of health equity. But it breaks from previous efforts by laying out a roadmap that **identifies the role of individual stakeholders** in achieving health equity and **describes the concrete actions that they can take** to address disparities. This creates both an impetus and a pathway for action on health disparities:

**The impetus—making the case for why we need to take action:**

- Disparities in care are avoidable, unfair and cost us all
  Disparities create unfair economic and social circumstances for individuals, communities and societies alike. They create fragility in health and social systems.

- Addressing health disparities is an urgent moral, social and economic priority that is reliant on a shared vision
  Without action, meaningful progress on societal health and economic goals is at risk and we remain vulnerable to threats like covid-19. A shared, forward-looking vision is critical to success.

**The pathway—identifying the barriers that stand in the way and how to overcome them:**

- Stakeholders and systems can either perpetuate or combat disparities
  Inaction can be as powerful as action. We lay out a clear route for various stakeholders to work cohesively in pursuit of health equity.

- Systems are slow to promote equity because they are often incentivised not to
  With a greater focus on equity-centred performance and targets, stakeholders and systems are more likely to both reduce disparities and achieve efficiency.

# Why health disparities are avoidable, unfair and cost us all

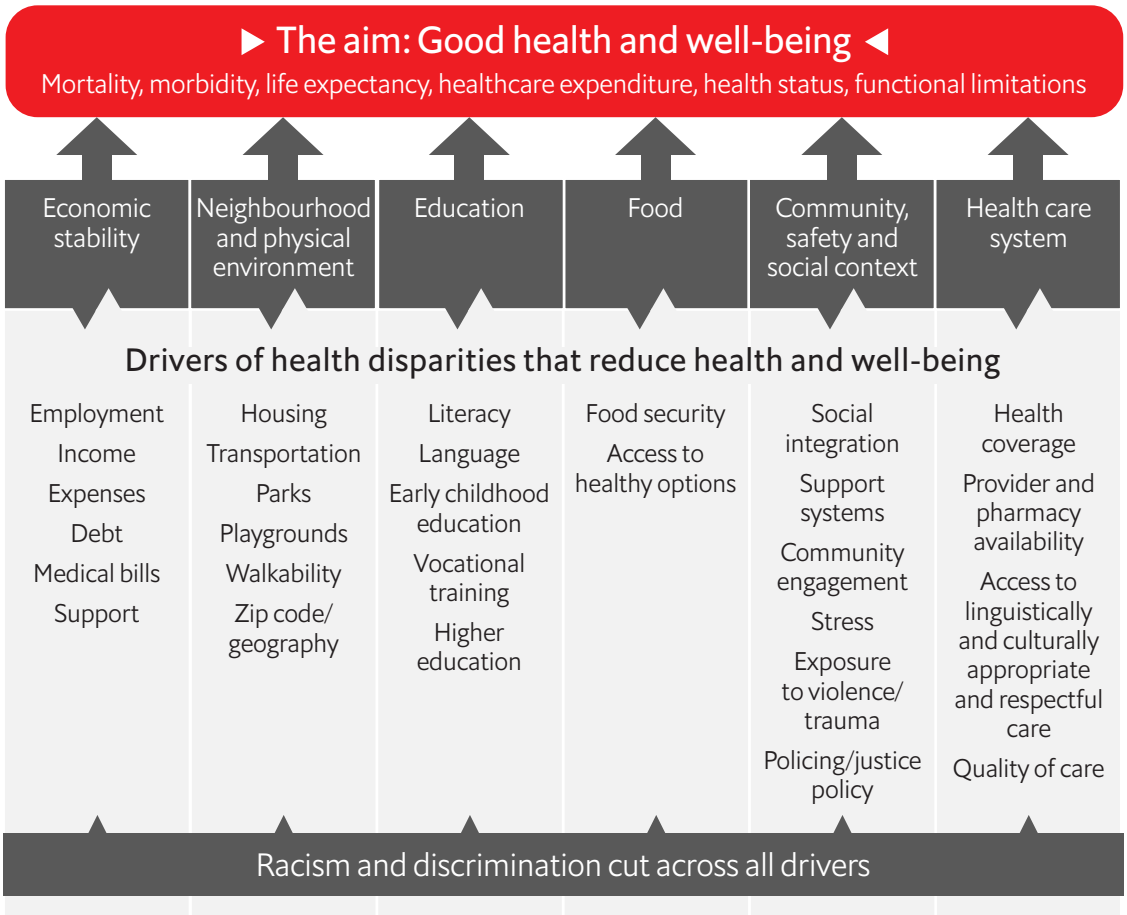
## There is a clear moral and economic case for eliminating health disparities and achieving equity in health

Health disparities are defined as avoidable and unfair differences in the health of people in particular groups; these disparities are often perpetuated by the ways in which health systems are designed.[1-3] These disparities include differences in the overall state of people's health, their life expectancy and access to and quality of care.[1-3] Factors linked to disparities include an individual's economic status, where they live, characteristics such as race and ethnicity, sexuality, gender, age, levels of ability and social exclusion or stigma. Most factors that drive health disparities are not considered to be directly health-related, rather they are the result of economic, policy-driven and socio-cultural disparities.[4]

> **"When you talk about any structural difference, it is that fact that it's systematic, unjust and avoidable that gives us something that we can and must definitely act on to change"**
>
> Vanessa Apea
> Consultant Physician in Genito-urinary and HIV medicine and Clinical Lead for Sexual Health, Barts Health NHS Trust

Figure 2 (below) illustrates how the overall aim of good health is undermined by various systemic, environmental, and socioeconomic factors that cause health disparities and reduce people's health and well-being. Left unchecked, community health outcomes may worsen, particularly for those at the margins of each of these drivers. See also Appendix 3 for further discussion of non-health related drivers.

**Figure 2: How health disparities are driven by social and economic disparities**



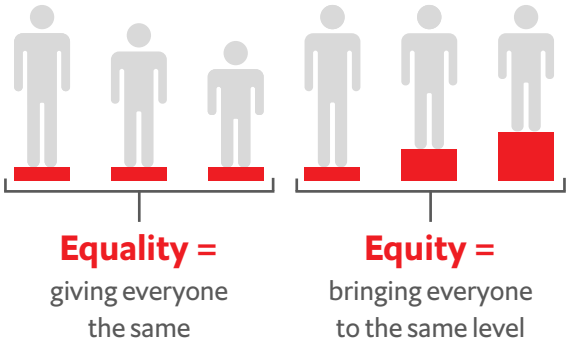

Source: Adapted from Artiga S. Health disparities are a symptom of broader social and economic inequities. Kaiser Family Foundation (2020). Available from: https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/

While each of these factors can be a significant cause of disparity independently, disparities tend to be intersectional—meaning that multiple factors are concentrated in certain demographics and in certain areas—further heightening health disparities for individuals in these overlapping groups. This is

sometimes referred to as cumulative disadvantage. For example, populations who are at higher risk or have greater incidence of mental illness or HIV and other STIs are likely to have inferior access to adequate mental health support.

In this report, we use "health equity" to refer to everyone in society having the same opportunities for good health. Equality broadly means giving everyone the same, regardless of any individual or social factors. By contrast, equity acknowledges the obstacles or disadvantages some people face and focuses on bringing everyone to the same level (see Figure 3).

Figure 3: The difference between equality and equity




Source: adapted from: Trimmel J. Inequality and inequity in eye health. Community Eye Health. 2016;29(93):1-3.

## The "cost" of health disparities

Health disparities impact millions of individuals in the UK and US alone, the two countries of focus in this study. To some extent, every case of inequity is a failure. Yet, equally, a failure represents a course that can be adjusted. Health disparities are most frequently cited as impacting individuals by reducing their health status and life expectancy. According to the Marmot Report, a landmark 2010 study of inequity in England, people dying prematurely each year because of health disparities would otherwise have enjoyed a total of 1.3m to 2.5m extra years of life.[3] This creates a clear economic impact, as people experiencing direct impacts of avoidable health disparities may be less able to participate in the workforce and may require more intensive care, either through the health system or family members.

A recent study demonstrates this impact directly. Ill health, disability and premature death due to health disparities could cost the UK an estimated £31bn-33bn in annual productivity losses, while

lost taxes and additional spend on benefits fall in the range of £20bn-32bn.[1] In the UK, it is estimated that about £5.5bn—a third of the annual budget of the UK's National Health Service (NHS)—goes to covering direct healthcare costs arising from disparities.[2] Whereas in the US, eliminating health disparities among racial and ethnic minority groups could have saved an estimated US$230bn in direct medical care and US$100bn in indirect costs in 2003-2006.[1] In another estimate, racial health disparities were projected to have cost insurers US$337bn in the US in 2009-18.[5] While the exact figures may vary, what is clear here is that we are talking about large amounts of money that addressing health disparities could save, freeing up those funds to be used for other purposes.

## Covid-19 has highlighted the impact of health disparities on us all

Covid-19 has broadly worsened existing disparities in health. In particular, it has impacted the health of many people with existing conditions, including HIV and other STIs, and people living with mental health challenges.

Although covid-19 has worsened existing disparities in health and beyond, it has also shone a light on them in new ways. Kelly Thompson, a Policy Analyst with the Research & Evaluation Group at Public Health Management Corporation, a non-profit headquartered in Philadelphia and addressing public health in southeastern Pennsylvania and across the country, notes:

> "No one really understood the impact of, for instance, not having health insurance [in the US] for so many essential workers until we had a pandemic where all of the industries [employing people] defined as essential workers often did not offer health insurance, paid people by the day or by the hour and didn't pay them a liveable wage."

These impacts on essential workers were almost universally felt and should serve as a wake-up call to leaders, health systems and other stakeholders that disparities pose a direct threat to realising the benefits of good health at the individual, community and societal levels.

Equally, much can be done to manage the threat of health disparities. This report aims to build on our understanding of the impact of health disparities, advancing this discussion by taking direct steps toward translating knowledge to action. In the sections below, we aim to identify the impact of health disparities in three health areas (HIV and other STIs, mental health and their intersection with covid-19), detail a shared vision of what health equity might look like and perhaps most importantly, chart the path forward within the context of UK and US systems. To support action, we identify what stakeholders may do to perpetuate disparities—to enable them to mitigate these risks—and the actions they can take to work together toward the urgent goal of health equity.

# Research aim and methods

The aim of this research is to develop a forward-looking framework for action. To make our findings actionable we focused on stakeholders and the steps they can take to either perpetuate or challenge health disparities.

To do so, we used a methodology combining an analysis of the past, present and future (see Figure 4). First, we conducted a literature review to assess the existing landscape, including both areas of interest and any gaps. The literature review comprised a highly focused search of health inequalities/disparities in the UK and US, limited to reviews published in the last 10 years. Searches included terms relating to health disparities, in major bibliographic databases: Medline, Embase, Cochrane, Epistemonikos and the Health Management Information Consortium. A potential limitation to this top-level searching approach is that it may not have captured the literature relevant to all potential drivers of disparity.

Figure 4: Methods summary


Source: Economist Impact

The UK and US were chosen as they are countries with wide ranging and ongoing health disparities, in spite of radically different health systems. This enabled us to explore the underlying drivers of health disparities in these two countries, highlighting that health disparities are the result of deep social structures and cannot be attributed solely to the health system organisation.

The focus areas of HIV and STIs, and mental health were selected because they are areas where disparities have a noted impact and both intersect with covid-19. In selecting very different health areas, we wanted to further explore the drivers of disparities, to show that it isn't just "an HIV problem" or "a mental health problem" but that disparities are an issue for the health system and society as a whole. We conducted additional searches to identify literature specific to these health areas.

Second, we conducted eight expert interviews to complement the literature review, and glean a practical perspective of health disparities and innovative ideas to counter them. Experts were selected

based on geographic and topical expertise. We identified key categories of interviewees: clinicians, social workers, epidemiologists, academics, community experts, patient representatives, advocacy organisations and policymakers or those familiar with policy. We interviewed the following experts:

- **Vanessa Apea**
  Consultant Physician in Genito-urinary and HIV medicine and Clinical Lead for Sexual Health, Barts Health NHS Trust, UK
- **Lisa Fitzpatrick**
  Founder, Grapevine Health; clinical professor at George Washington University School of Medicine, US
- **Angela Kimball**
  National Director, Government Relations, Policy and Advocacy, National Alliance on Mental Illness, US
- **Melissa Marx**
  Assistant Professor, Department of International Health, the Johns Hopkins Bloomberg School of Public Health, US
- **Homero E. del Pino**
  Associate Professor, Charles R. Drew University of Medicine and Science, US
- **Ibidun Fakoya**
  Research Fellow, King's College London, UK
- **Liz Sayce**
  Chair of the Commission for Equality in Mental Health, hosted by the Centre for Mental Health, UK
- **Kelly Thompson**
  Policy Analyst, Research & Evaluation Group at Public Health Management Corporation, US

Based on the literature review and interview findings, it was clear that there was plenty of literature describing disparities and their impact, but less on the actions needed to address them. As such, our analysis focused on creating a practical vision of a future without health disparities, then identifying the relevant stakeholders and attributing actions to them, to make that vision a reality.

To explore what a shared vision of eliminating health disparities could look like, we used a foresight methodology to look at what has been done historically, explore what is currently being done and then imagine what the future could look like. This involved the following key steps:

- Defining what the future could look like if disparities were eliminated

- Identifying what needs to happen to eliminate health disparities:
    1. What actions are currently perpetuating health disparities?
    2. What actions need to be taken to eliminate disparities?
    3. How to make that happen by attributing actions to stakeholders

While we acknowledge that many international health-related targets are set for the year 2030, we explore a longer-term time horizon of 2040. The 20-year time horizon is frequently used in foresight work as a benchmark to guide thinking about systems-level change. This kind of thinking allows us to gain insight about short-term actions and targets, while taking a longer-term view of the opportunities at hand to address disparities. This longer timeframe does not negate the important work being done to make substantial progress by 2030, but instead allows for a framework to think about further goals and actions that could create more systemic change over time, in addition to reaching shorter-term targets.

# What health disparities currently look like: HIV and other STIs, mental health and the COVID-19 connection

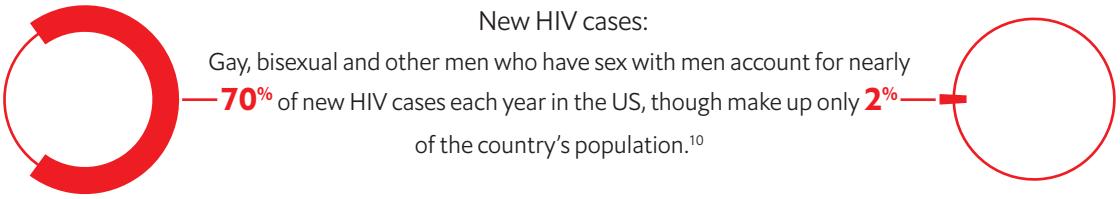
Health outcomes are rarely due to the nature of the disease alone, but are driven by underlying health disparities. In this study, we focus on the role and patterns of health disparities among people living with HIV and other STIs, mental health concerns and covid-19. Our initial research identified clear and documented health disparities within these topic areas and that the disparities in these health areas are connected by broader social factors, rather than driven by topic-specific factors.

Disparities in HIV and other STIs and mental health have only been made more evident in light of the covid-19 pandemic. In both the UK and the US, the pattern of poor outcomes and deaths due to covid-19 have replicated pre-existing health disparities observed in other conditions.[6,7] Groups already experiencing poorer health outcomes have been less able to protect themselves from exposure to covid-19, have experienced more acute illness, have been more likely to die from the disease, or have endured poorer quality of life and mental health than others during the pandemic. According to a forecast published by the Centre for Mental Health in May 2020, at least 0.5m additional people in the UK may experience mental illness because of covid-19.[8]

As one might expect, lower-income earners in the UK tend to fare better in terms of health outcomes due to access to the NHS system when compared with the US.[9] The highly siloed US health system and coverage landscape often leaves the most vulnerable to suffer the effects of systemic disparities. Yet recent studies comparing outcomes in the US and UK still showed similar significant differences among income groups in the UK. This means that despite notably greater access to care in the UK with far less economic burden placed on individuals, health disparities still exist. This points to the complexity and magnitude of the threat of disparities across health and social systems in countries like the US and UK and beyond.

## HIV and STIs

Clear racial disparities exist in relation to HIV. In the US in 2018 Black individuals made up 41% of people with HIV despite only representing 13% of the population.[10] Similarly, Hispanic/Latinx individuals represented 23% of people with HIV while comprising 18% of the population.[10] Another, and even starker, disparity exists for gay, bisexual and other men who have sex with men (MSM). This population accounts for nearly 70% of new HIV cases each year in the US, though they make up only 2% of the country's population.[10]




Though factors such as the number of sexual partners, drug use and others are often assumed to be the sole drivers of these disparities, the evidence demonstrates otherwise. Although Black MSM are five times as likely as white MSM to have HIV antibodies, Black MSM report lower rates of substance misuse, fewer sexual partners and are also more likely to use condoms.[11] Black MSM are known to have higher rates of treatment, while also experiencing higher rates of poverty, incarceration and unemployment.[12] This significant gap between HIV risk and behaviours is an urgent indicator of the impact of disparities.

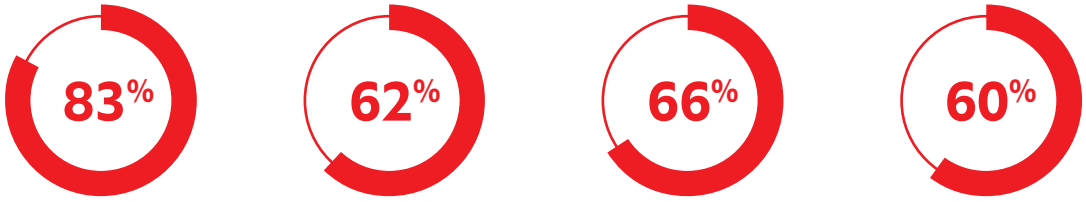
As with other disease areas, there are gaps in HIV research that also impact our fundamental understanding of these disparities, as well as effective approaches to HIV prevention and treatment that may help mitigate them. For example, in the US, Black and Hispanic/Latinx people living with HIV are under-represented in clinical trials for a variety of reasons, including a failure to counter mistrust of medical research, unsupportive social norms and lack of referral.[13]

It is also important to note that there are clear similarities and crossovers in the disparities faced by those affected by HIV and other STIs. For example, race and ethnicity-based differences in STI diagnosis and rates cannot be explained by differences in healthcare seeking and use.[14] The drivers of disparity for STIs tend to be the same as for HIV: education, employment, male incarceration, drug and alcohol marketing and social capital are all factors.[15] Individuals who are often short-changed when it comes to education and economic opportunity are also targeted by drug and alcohol marketing tactics. Drug and alcohol use is often associated with riskier health and sexual behaviour and is linked with increased chances of contracting an STI.[15]

These same factors also result in higher rates of male incarcerations, which alter the ratio of males to females in communities; this is also known to increase the spread of STIs. Rural populations also face greater disparities in regards to STIs. For example, in the Mississippi Delta region of the US, rates for STIs are significantly increased in more rural and less populated areas, largely due to a lack of access to health providers and information on STIs.[16]

Screening rates for gonorrhoea and chlamydia among people living with HIV fall well below recommended rates; these gaps in screening have been significantly exacerbated during the covid-19 pandemic. Missed medical appointments and other interruptions to care during the pandemic have independently been associated with an increased risk of developing conditions associated with AIDS and death.[17] In some cases, social responses to covid-19 have adversely impacted access to testing, treatment and medication adherence in the UK and US.[18,19] According to a covid-19 impact assessment in the US, nearly 1 in 5 participants (19%) missed a scheduled HIV care appointment in the previous 30 days, with 45% citing covid-19 as the direct cause.[20] Furthermore, 40% of study participants also reported that a non-medical service provider contacted them to cancel an appointment due to covid-19.[20] In the UK, Public Health England found testing for HIV fell 35% from January to September 2019 to the same timeframe in 2020, while testing for chlamydia, gonorrhoea and syphilis dropped 30%.[21] Young MSM are disproportionately impacted by HIV and STI service interruptions.[22] This points to a need for continued monitoring to identify the long-term impacts of the pandemic on health outcomes for HIV and other STIs, especially in light of existing disparities (see Figure 5).[23]

Figure 5: Impact of covid-19 on HIV and STI services in the US




Source: National Coalition of STD Directors / NASTAD.[23]

Accordingly, several US models have attempted to capture potential consequences of sustained HIV and STI service interruptions. Increases in HIV acquisitions and HIV-related deaths are projected with treatment interruptions and in the absence of changes to sexual behaviour. In this worst case scenario, an HIV transmission model projects a 9% increase in HIV acquisitions across cities, with 50% reduction in services.[24] Another similar study proposes an 11% increase in HIV-related deaths over one year and a 2.6% increase in deaths over five years, with continued service interruptions.[25]

This report is accompanied by a case study which profiles HIV further, including how disparities in HIV screening, diagnosis and treatment are a direct threat to achieving HIV/AIDS targets more widely.

**“ People seem to forget with the singular focus on covid-19 vaccines, still the most important thing we can do is find cases and interrupt transmission. The same is true for STDs and HIV, case finding is the gateway to care and treatment so people can access the support they need.”**

Lisa Fitzpatrick
Founder, Grapevine Health; clinical professor at
George Washington University School of Medicine

## Mental health

There are pronounced disparities in access to and utilisation of mental health services based on race and ethnicity, income, gender, age, cultural perceptions of healthcare and a variety of other factors.[26] In terms of race and ethnicity, Public Health England states that people from minority ethnic groups are more likely to seek help in a crisis situation, be admitted to hospital, experience poor outcomes and disengage from services.[27] In the UK, for example, members of minority racial and ethnic groups are more likely to be detained against their will or receive coercive treatments, owing to increased police contact, greater perceived threat of violence and mistrust of healthcare providers.[28] Black people in the US are also likely to have worse access to mental health screening, diagnosis and treatment, while indigenous populations in the US are at a high risk of adverse outcomes such as

post-traumatic stress disorder (PTSD), depression, suicide and substance misuse.[29,30] A race-based disparity has existed largely unchecked in schizophrenia diagnosis in the US for over three decades.[31]

When compared with pre-pandemic data, the prevalence of mental health disorders drastically increased during the covid-19 pandemic. In June 2020, 40.9% of respondents to a US Centers for Disease Control and Prevention survey reported experiencing at least one adverse mental or behavioural health condition, which is 3-4 times greater than the rate of the previous year.[32] A smaller, longitudinal study in the UK reported similar findings, with the prevalence of mental health issues increasing by 13.5% among study participants in April 2020, compared with data obtained in 2017-2019.[33]

**" I think training for clinicians and service providers around historical inequity and discrimination, and how to properly address those things, how to understand bias, racism, unconscious bias would do a lot to address the disparities that we see in mental health, STDs, etc"**

Kelly Thompson
Policy Analyst and Legal Epidemiologist,
Public Health Management Corporation

## The benefits of tackling health disparities

### *For individuals and families*

The major advantage of tackling health disparities for individuals and families would be the enhanced ability of people to actively pursue good health and have control over their own health and, ultimately, to live fuller lives. When thinking about health disparities at an individual level, Vanessa Apea, Consultant Physician in Genito-urinary and HIV medicine and Clinical Lead for Sexual Health at Barts Health NHS Trust, says that we have to consider "whether individuals have the capability, opportunity and motivation to utilise healthcare". An improved individual capacity to maintain good health can translate to: less risk of financial hardship, depression and anxiety; the ability to pursue education; and the capacity to make better life decisions and act on them.

Groups that have faced mistreatment and disparities in the past can be mistrustful of health services. Addressing health disparities to enable such groups to access health services without fear or apprehension could enable earlier intervention, which is helpful across a wide range of health conditions. For example, factors such as implicit racial bias in medical textbooks and literature should be challenged, and diversity in teaching faculty increased.[34,35] "It's about how do we build trust, a sense of safety, a sense of security and belonging," says Kelly Thompson, Policy Analyst at the Public Health Management Corporation.

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Technological solutions can also support addressing disparities; for example, the use of telehealth can enable health services to reach groups that are remote or hard to reach in multiple senses. In mental health Angela Kimball, the National Director for Government Relations, Policy and Advocacy at the National Alliance on Mental Illness, describes how "we need to open the door to telehealth and make it widely available all the time". Covid-19 created a necessity for broader implementation of telehealth and has shown that it is possible and desirable to do so. We also need to acknowledge and seek to address any technical and financial barriers to accessing telehealth (the digital divide). National organisations, for example, can be catalysts for action in terms of technological solutions by spearheading research agendas (eg National Institute for Minority Health and Health Disparities in US) that advance the field of health informatics, which has underexplored opportunities to ameliorate disparities.[36]

## *For communities and networks*

An equitable health landscape could provide scope to improve the diversity of engagement in research. As Lisa Fitzpatrick, a clinical professor at George Washington University School of Medicine and founder of Grapevine Health, puts it "clinical trial sites are never in the community" and there is a need for consistent community outreach "to build trust and educate the community about the benefits and availability of clinical trials".

Addressing health disparities is in part about understanding where they come from. Homero E. del Pino, Associate Professor at Charles R. Drew University of Medicine and Science, talks about a lack of awareness of therapies such as pre-exposure prophylaxis (PrEP) in Latinx communities: "a lot of [my study participants] said, 'Why isn't this in our communities more? Why don't we see more billboards? Why isn't this on [Spanish language TV channel] Univisión?'" So simple steps like understanding the right media and outreach channels to use to connect with communities could address disparities and improve the health of these communities.

For instance, The Birmingham and Solihull Mental Health Foundation Trust in the UK designed a novel programme to promote youth-specific services and improve mental health accessibility and outcomes (Youthspace).[37] In this programme, they found using social media and internet technologies were successful in increasing influence and programme awareness.[37] Unfortunately, this service only covers one city. Collective and widespread efforts need to be tailored to consider the communities they intend to serve. Involving members from target communities in the planning and implementation process is an effective way to ensure outreach measures are appropriate.

Accordingly, research affirms the benefit of utilising Community Health Workers (CHWs) in intervention delivery; namely, mental health symptom reduction among underserved populations in the US and in low- and middle-income countries.[38] Yet, widespread use of CHWs, particularly those from the communities they serve, has not been widely adopted in the US and UK despite the potential to address health disparities across sectors.

## *For populations and systems*

The ultimate population-level consequence of achieving health equity, whether viewed in terms of society, economics, politics and from a whole host of other standpoints, is a healthier, longer-lived population.

To eliminate disparities would require health equity to be a guiding principle of national and local health and economic strategies. Putting health equity at the centre of policy making and strategy, with the necessary tools to support implementation, would embed it within health services, local authorities and governments. In this regard, efforts have been made such as the Ryan White HIV/AIDS Program (RWHAP), a US federally funded programme that functions as a safety net for uninsured and under-insured marginalised populations living with HIV.[39] This programme has been successful in addressing accessibility and affordability of care for minority groups (contributing factors to HIV health disparities). To continue the work of eliminating disparities and avoid short-sighted efforts, any cost savings from programmes like these must be leveraged as evidence in policy decision-making.[40] Risk of HIV worker burnout in these types of programmes is also a concern and potential barrier to successful implementation, requiring advance consideration in policy making and strategy.[40] Policymakers must amplify such strategies to expand resources and attention to health equity efforts.

Increasing the diversity of the healthcare workforce could also help to address health disparities as it would help to increase the diversity of ideas, lived experiences and approaches to solving health problems and disparities. Liz Sayce, Chair of the Commission for Equality in Mental Health, hosted by the Centre for Mental Health, describes the current "snowy, white peaks" of health leadership by explaining that "many of the people working in [UK] health services are Black British people, people from minority communities, people from the Asian subcontinent, etcetera. But once you get to the senior levels, it's very, very white." This may limit ambition and motivation to address health disparities.

Bias among health workers is a barrier to effective care that has consequences at the individual level and, in aggregate, for overall public health. Such bias can be addressed through a greater acknowledgement of disparities in medical education and increasing diversity in teaching faculty.[34,35] In the US, some medical institutions have attempted to address bias in care and medical education through mandatory courses, providing strategies for provider resistance to bias training, perspective-taking and team learning activities, however, these interventions have fallen short.[41,42] Bias recognition and mitigation cannot be reduced to one course or training session. Rather, institutional efforts must emphasise that eliminating disparities is a shared responsibility requiring agreement on multi-strategy approaches with continued exposure and opportunities for practice among medical students, healthcare workers and healthcare institutions at large.[43,44]

## How do these disparities differ in the US and UK?

Comparison of the UK and US healthcare systems can provide insight into the root causes of health disparities because these systems differ so much in their structure. The UK's universal health coverage under the NHS stands in contrast to the US's primarily fee-for-service system involving numerous private and public insurance schemes. Identifying root causes can then inform policy change and stakeholder action across these types of systems, no matter where they are located. See Appendix 2 for a top-level comparison of the US multi-payer and the UK universal health systems.

Despite stark differences between the structures of the US and UK systems, disparities persist in both countries. In the US and UK, similar racial and economic disparities are observed (eg higher rates of HIV among Black MSM and poorer mental and physical health outcomes at lower income levels).[45] Yet despite these similarities, the two countries differ in terms of how health disparities are tackled. Research shows that the US often focuses on direct healthcare issues (ie access, insurance coverage) and racial politics, whereas UK health disparities often refer to wider social issues that can have an impact on health (eg people's income, where they live).[46]

It is important to note that, despite ongoing gaps, the US and UK are attempting to eliminate disparities. These efforts include establishing multilevel measurements of health disparities, research and development programmes and oversight agencies. Still, there remain challenges to their sustained and widespread implementation. For example, accessing quality data and utilising incentives to enforce institutional- and individual-level actions are historical challenges.[46] Current efforts to reduce health disparities are important to recognise, but holistically do not go far enough to achieve the goals laid out in this report.

# Defining the vision of achieving health equity

**"We're in this loop – a hamster wheel of focusing on individuals and helping them improve their agency and increase their autonomy, but where are we sending them back into? The situations in which they make unhealthy choices haven't changed... we forget that we make these choices in an environment"**

Homero E. del Pino
Associate Professor,
Charles R. Drew University of Medicine and Science

With so many aspects of disparities being deeply engrained throughout health and social systems in countries like the US and UK, it can be hard to imagine what a system without them could look like. However, the evidence shows that disparities are deeply damaging to individuals, communities and societies alike, posing a significant threat to the sustainability and progress of health systems. Much is known about the existence and drivers of health disparities, yet action is slow and wholly inadequate.

In determining where progress can be made, a shared vision of what achieving health equity looks like is an essential first step. Without this, health systems and organisations risk making disparities worse by operating in a silo. However, systems are generally incentivised to maintain the status quo, making change all the harder. In addition, any vision of the future can be constrained by past and present experiences. Instead, we can look to historical and current trends to indicate what might be possible to achieve over a defined period of time and their consequences for individuals and families, communities and networks, and systems and countries. More detail about the foresight analysis and how we developed these scenarios is included in Appendix 4.

For example, as we think about how the world moves forward from the pandemic, we can imagine that covid-19's spotlight on disparities may create momentum around considering equity as a more central performance measure of health systems. As such, improvements in technology to measure and promote equity, as well as greater focus on preventive health and primary care (central to

achieving health equity) take place. Defining these goals means that stakeholders can then more readily work together to effectively address disparities, using their relative resources and strengths. As Vanessa Apea stated, "Healthcare access, use and utilisation at all levels is driven by human decision-making," underscoring the importance of this work in aiding that decision-making process.

The scenarios below apply the evidence from our three health areas of focus to define a vision for the future in the pursuit of health equity by 2040. These three health areas demonstrate how health disparities affect all aspects of health services and the opportunities that could be created through their elimination in these specific health areas and beyond. Selecting 2040 gives us a long enough timeframe to be ambitious about what we aim to do, showing the impact this vision could have, balanced with a clear roadmap of the actions needed in the intervening years to get to that point.

## *Covid-19 has become a blueprint for equitable health preparedness and protection*

**The scenario**

In the year 2040, covid-19 is recognised as a key historical exemplar of how disparities in outcomes can be bridged.

**What this new world looks like**

Covid-19 highlights to governments the value in focusing on improving the overall "health stock" of their populations—ie making their populations generally healthier—to reduce the impact of future pandemics on vulnerable groups. By reducing health disparities, governments can make these groups healthier overall and reduce the undue impact of future pandemics on them. Positive economic and social impacts follow, enabling leaders to see good health as a tool toward reaching key societal goals.

Governments invest in data collection systems that collect equity-informed data to enable the monitoring of health disparities and their linkage to specific diseases (including pandemics). This enables the evaluation of any interventions to reduce health disparities and long-term trend analysis.

There is also a greater push for connectivity (expanded and faster broadband roll-out) in recognition of the role of information during pandemics and to combat disparities that emerge or are worsened because of a lack of access to reliable, high-quality information.

**Potential outcomes**

- Improving the overall health status of the population (focused on groups affected most by health disparities) would enable greater resilience to future pandemics for individuals, societies, health systems and economies, and protect against negative economic impacts of health issues.

- Collecting data on population health that can be better linked will give greater visibility on any areas of vulnerability (groups, areas, diseases) and enable the creation of specific initiatives to address them, which in turn can be evaluated using these datasets.

- Improving access to information across the population can improve health literacy and health status overall. During a pandemic in particular, it is a crucial tool for countering mis- and disinformation, enabling people to better protect their own health.

## *The global HIV epidemic comes to an end*

**The scenario**

The international community doubles down on eliminating HIV and succeeds over the next 20 years. While prevention efforts remain in place, resources for treatment shift to other priorities, raising health access, quality and trust among vulnerable populations.

**What this new world looks like**

HIV services become a blueprint for the broader health system to create a model of care that effectively prevents new cases, rather than focusing on treating people who are already ill. A key element of this service redesign is equitable access to prevention services and patient-centred and preference-sensitive choices for treatment, including the elimination of stigma. Innovations like a successful vaccine and treatments can put people into HIV "remission" and effectively mitigate any further risk of spread.

In addition to a change of vision in service delivery, the focus of research, development and innovation also shifts towards prevention and screening. This supports the development of prevention-first service models and ensures a steady supply of innovations that can improve services over time (evaluations of models of service delivery, innovative medications, risk-reduction research).

**Potential outcomes**

- Reducing the impact of HIV on individuals (including reduction of stigma), health systems, economies and societies: allowing individuals to live healthier lives, reducing the strain on health systems, increasing productivity in the labour market and lowering the burden of disease across society.

- Freeing up budget that would otherwise have been spent on treating new cases, to spend on prevention and in other areas.

## *Mental health is the connector for bridging the gaps between public health and healthcare*

### The scenario

To achieve equitable access to mental health services by 2040, health systems, the justice system and other areas continue to drive better integration of mental health into primary care and create services that are more sensitive to the needs of diverse populations.

### What this new world looks like

Services shift focus to preventive and proactive delivery, to prevent mental health crises, rather than simply responding to them when they happen. In the US this would require transformation of Medicare mental health eligibility criteria to enable earlier access to treatment.

Better coordination between healthcare, public health systems and law enforcement improves understanding of mental health to enable better management outside health settings. Greater involvement of schools and employers leads to greater access to effective resources for mental health for a wider range of the population.

Greater inclusion of people with mental health problems in the health system enables service redesign that is person-centred and addresses the needs of people with mental health.

### Potential outcomes

- Focus on preventive and early intervention services across the health, education and labour sectors improves people's overall mental health, enabling them to "live better".
- Earlier intervention reduces crisis management costs for law enforcement, the health system, welfare state, health insurers and individuals.

# Getting from here to there: key next steps towards health equity

**" Not everyone knows how to achieve equity. Giving people tools, buddying them with a company/ entity that has expertise in it, and putting in the resource to enact change. It is important to articulate in words and scenarios what is right and best practice"**

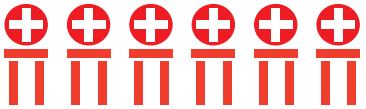
Vanessa Apea
Consultant Physician in Genito-urinary and HIV medicine and
Clinical Lead for Sexual Health, Barts Health NHS Trust

These scenarios of feasible change over time begin to uncover the pathway from identifying existing health disparities and their root causes, to anticipating the impacts that these actions could have. In doing this, we begin seeing glimmers of strategic opportunities for different stakeholders to work toward these ideal outcomes. These scenarios represent the ways in which disparities are currently holding us back from progress in key health areas like HIV and STIs, mental health and covid-19, and how addressing them is often the first step toward better health overall.

One of the key aims of this research is not just to describe health disparities and their impact, but also to provide an actionable roadmap for health equity to help alleviate the lack of action in this area. Table 2 shows crucial steps to achieving this aim, as we describe some of the key actions needed across stakeholder groups to move from the current landscape to achieving health equity.

Existing roadblocks to health equity include disincentivised prevention- and equity-focused care, financial waste, siloed efforts for change and lack of innovation. These present important opportunities to reshape the current landscape for a more equitable future. Such opportunities include centring public health and primary care services in healthcare delivery, restructuring fiscal priorities beyond direct cost savings, and pursuing a coordinated, multi-sectoral stakeholder response to disparities. If action is taken now, achieving health equity can become a reality.

Table 2: Getting from here to there: health equity by 2040



| The current landscape | The road to health equity | Envisioning health equity 2040 |
|---|---|---|
| **Acute, reactive care that incentivises the status quo:** Health systems are still focused on treating the sick, rather than preventing illness by improving the health of the population, and incentives are more aligned to efficiency-related goals, which creates disincentives to treat those who need it most. People who experience disparities often access care later, once they are much sicker, which contributes to worse outcomes. | **Restructure health systems to incentivise prevention for both physical and mental health:** Using different reimbursement and incentive schemes and setting core targets that prioritise value for measurements of quality, equity and sustainability can realign the incentives of providers. Alongside different payment models, public health and primary care providers should be equipped with appropriate resources, training and support that reflects their community's needs. | **Expanded access to equitable public health and primary care services:** Evidence shows that primary and preventive care is one of the best places to start in increasing the overall health of the population. Focusing on primary care as a core strategy to mitigate disparities brings a multitude of benefits to individuals, health systems, society and the economy as the 'health stock' of the population rises. |
| **Disparities lead to resource-intensive care and wasted investment:** Disparities in care create high costs to the health system and individuals, and serve as one of the primary barriers to reaching important goals in improving health care systems and outcomes. Health systems end up spending more in dealing with the consequences of disparities than eliminating them in the first place. | **Reimagining investment beyond the upfront cost:** Expanding the evidence for understanding the social, health and monetary value of eliminating disparities is crucial to catalysing change. Looking at investments over longer term horizons and using different measurements of "success" can aid in achieving this end. | **Increased fiscal space for other priorities:** Focusing on services that promote good health and early interventions to better manage health conditions across diverse populations can free up resources from expensive reactive and acute services. This fiscal space can be reinvested into these preventive services and other health priority areas. |
| **Silos among stakeholders:** Individual stakeholders can make a difference, but their impact is limited in the absence of collaboration and system-wide reforms that create an enabling environment for health equity. | **Focusing on individuals' capability, opportunity and motivation:** Stakeholders can use this framework to prioritise and realign their goals around improving equity. Practically this could look like improved data sharing practices, efficient referral processes and better communication between community initiatives, public health and health providers. | **A shared vision for a collaborative and systems-oriented approach:** Stakeholders need to coordinate action around an agreed vision that is driven by best practices. Rather than unsustainably patching holes in systems, the systems themselves should be rebuilt according to input from all stakeholders. |
| **An innovation gap:** Many health systems continue to use largely unchanged methods to engage stakeholders or rely on community partners to pick up the slack. Without rethinking who these stakeholders are, health systems are missing opportunities to engage and influence. | **Improving our understanding of how individuals receive and act on information:** Incorporating new disciplines from outside of the health sector in planning and organisational structure could expand the current knowledge of how to reach certain populations. Understanding the locus of responsibility does not lie strictly within the health system is a start. | **Mapping a new, more advanced stakeholder landscape:** The sources of influence over health and health systems have changed in recent years, meaning that we need to rethink who is included in the stakeholder ecosystem, while also thinking beyond traditional stakeholders to novel influencers to create effective change. |

# Turning vision into action: identifying and mobilising an ecosystem of stakeholders towards health equity

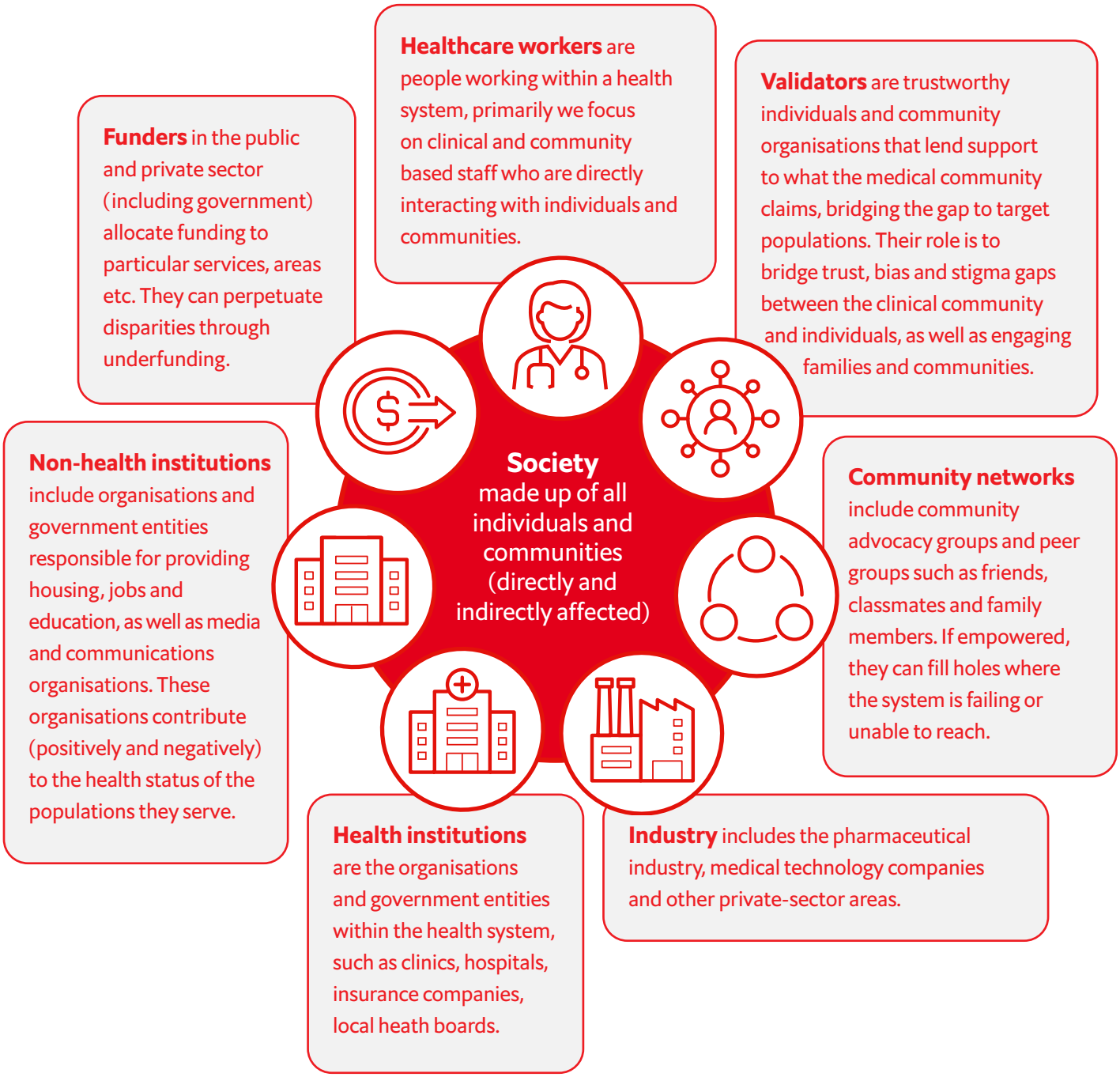
The central aim of this research was to create an actionable roadmap for achieving equity; to do so we first need to identify and define the relevant stakeholders. Vision can only become a reality if the correct stakeholders are identified and given specific roles that enable them to contribute to meaningful change. The intersectional nature of health disparities means a wide variety of stakeholders have a role to play in both perpetuating and mitigating the drivers of health disparities.

## The stakeholder ecosystem needs to achieve health equity

Our research identified and defined seven core groups of stakeholders who play an important role in the health disparities landscape. While not necessarily exhaustive, these stakeholders are among those who most directly influence health disparities and are therefore part of the ecosystem for addressing health disparities (see Figure 6). For example, validators (which refers to prominent and trustworthy community members such as a religious leader or a teacher) are key players in supporting medical community claims and can bridge trust and stigma gaps between healthcare professionals and communities.

Similarly, non-health institutions contribute to community health by providing safe and secure housing and jobs, without which care accessibility is negatively impacted. At the centre of this ecosystem is society (made up of all individuals and communities directly and indirectly affected), consideration for which should be at the heart of actions by all stakeholders.

Figure 6: The health equity stakeholder ecosystem




Source: Economist Impact

## Who needs to do what to achieve health equity?

Our aims in envisioning health equity are ambitious but achievable, with an approach centred on an ecosystem of stakeholders working together cooperatively and collaboratively to achieve this common goal. We are clear that individuals are not responsible for changing health systems; health systems are responsible for developing to better serve individuals.

In Figure 7 we present an in-depth analysis of how each of these stakeholder groups can perpetuate disparities and how they can contribute to achieving health equity, based on the literature review and interviews.

While these stakeholders have the opportunity to implement change in systems that perpetuate disparities, they also equally risk perpetuating disparities themselves through slow or inadequate action. We identify how these stakeholders can risk perpetuating disparities, for example through the use of clinical decision-making tools that are inherently biased or collecting data that uses such broad groupings that deep understanding of disease dynamics, socioeconomic or cultural challenges is almost impossible. In doing so, we can also identify opportunities to manage these risks, and make efforts to address disparities more likely to be successful.

**“ I would pessimistically say that we’re going to lose people’s attention as public health funding decreases and other issues become louder. I think substantial changes need to be institutionalised now... then stakeholders will know they’re consciously under-resourcing rather than passively neglecting these issues.”**

Melissa Marx
Assistant Professor, Department of International Health, the Johns Hopkins Bloomberg School of Public Health

Figure 7 (part 1 of 2): How stakeholders can perpetuate and challenge health disparities: an analysis of the health stakeholder ecosystem[36-39,41,42,44,47-58]

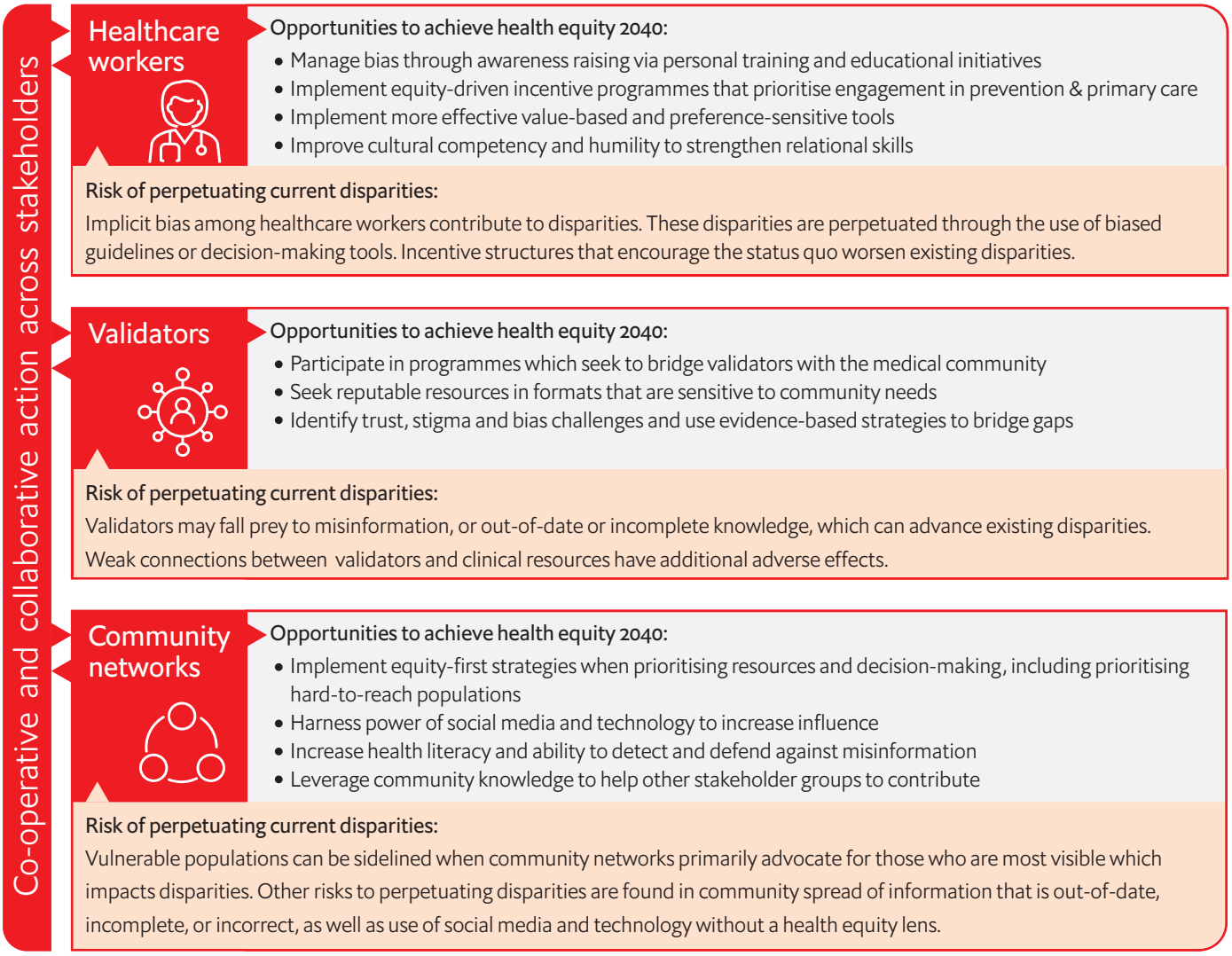


Figure 7 (part 2 of 2): How stakeholders can perpetuate and challenge health disparities: an analysis of the health stakeholder ecosystem[36-39,41,42,44,47-58]

Co-operative and collaborative action across stakeholders

## Industry

**Opportunities to achieve health equity 2040:**

- Adopt equity as a central business practice, implement key performance indicators and effective measures to continuously monitor progress
- Consider unique needs of vulnerable communities and incentivise inclusion; implement genuine trust-building strategies alongside other stakeholders
- Seek to diversify health industry, particularly among leadership, research, marketing, lobbying and consultant staff

**Risk of perpetuating current disparities:**

Vulnerable or hard-to-reach populations are often excluded from R&D or access strategies. Some industries also lack of collaboration with safety net programmes and community resources to manage costs which furthers existing disparities. In some cases, discrimination and bias is found in advertising/marketing efforts.

## Healthcare institutions

**Opportunities to achieve health equity 2040:**

- Adopt more robust data collection methods, including disaggregation and vital signs for non-health determinant factors
- Strengthen collaboration across stakeholder groups and boost the visibility of the public health and social services sectors
- Provide resources for clinicians to grow awareness and manage implicit bias, including providing equity-centred protocols and tools
- Prioritise a diverse workforce and create avenues for greater diversity in leadership roles

**Risk of perpetuating current disparities:**

Within some healthcare institutions, there is a lack of effective data collection to capture disparities and of collaboration with public health and social services sectors. Incentivisation to maintain the status quo within these institutions negatively impacts disparities.

## Non-health institutions

**Opportunities to achieve health equity 2040:**

- Participate in data exchanges and explore opportunities for stronger data integration with other agencies and sectors
- Work with other partners to embrace cross-agency navigators who employ effective person-centred tactics
- Develop stronger ties with the research community to implement evidence-based strategies and decision-making guides

**Risk of perpetuating current disparities:**

Amongst some non-health institutions, poor data integration across sectors exists in addition to a lack of client-centred navigation across health and non-health needs, along with Insufficient decision-making frameworks needed for prioritisation.

## Funders

**Opportunities to achieve health equity 2040:**

- Embrace strict criteria for funding programmes and initiatives that are equity-centred
- Implement criteria to evaluate effectiveness of programmes and strategies for their potential for reducing disparities
- Boost funding for communities that are more vulnerable and harder to reach

**Risk of perpetuating current disparities:**

Similarly to other stakeholders, funders are incentivised to maintain the status quo. Accordingly, some have a low tolerance for risk or more innovative initiatives. There is also a tendency to fund stakeholders and programmes that target easier to reach or more visible populations.

## How we incentivise healthcare systems to change

Incentives are a critical part of driving change among stakeholders because they encourage certain behaviours and ways of working. Equally, disincentives can work against change by making new ways of working unprofitable, more hassle or mean that they provide no advantage to stakeholders over their current ways of working.

Disincentives to providing equitable care exist at nearly every level of healthcare and directly threaten the success of stakeholders in being able to collectively achieve meaningful progress. A few reforms in payment (referring to reimbursement for providers) specifically in the US have targeted disparity reduction, while other measures such as efficiency are prioritised. Additional barriers to incentivising disparity reduction include limited racial diversity of patients in many care settings, challenges with measurement and the lack of an interactive quality improvement approach.[59]

> **"So, it's this perverse, economic disincentive to actually provide the very community-based services that we want."**
>
> Angela Kimball
> National Director, Government Relations, Policy and Advocacy, National Alliance on Mental Illness

To combat this, a combination of "can do" factors (enabling) and "will do" (incentivising) factors are needed.[60] "Can do" refers to actions such as proper training, adequate working conditions, sufficient resources and other necessary organisational needs that can enable providers and other stakeholders to practise and support high-quality, equitable care. "Will do" factors are aimed toward intrinsic motivations and can include structures such as strong recognition for good work, mechanisms to receive appreciation from patients and alignment with certain ideals.

Stakeholders are much more likely to be able to challenge the status quo and achieve progress by incorporating incentives into the organisational design of forward-looking visions of health equity, such as the one we lay out.

This report is accompanied by an in-depth case study which profiles strategies to incentivise equity across the different stakeholder groups that this report identifies.

**“ And so the question is, why aren’t we seeing changes on a population level? Is it because we’re largely measuring the wrong things, or paying for things that don’t link directly to a person’s health outcomes. Are the solutions we are paying for arresting pre-diabetes, preventing progression to kidney failure or keeping people out of the hospital? These are the measures we should be paying for, but sadly that’s not how the system is structured.”**

Lisa Fitzpatrick
Founder, Grapevine Health;
Clinical professor at
George Washington University School of Medicine

# Conclusion: Moving from words to action

Discussion about health disparities and the huge impact of health disparities on individuals, communities and whole societies has not been lacking. What has been lacking is action.

The overarching aim of this research is to take what some might consider an aspirational target, show that it is achievable and lay out a roadmap for how it can be achieved. Our research identifies the following critical considerations that can help take us from simply talking about health disparities, to taking action to address them:

## Making the case for why we need to take action:

- **Disparities in care are avoidable, unfair and cost us all.**
  Disparities create unfair economic and social circumstances for individuals, communities and societies alike. They add fragility to overall health and social systems, even when designed around universal access, like the UK's NHS.

- **Addressing health disparities must be an urgent moral, social and economic priority and starts with a shared vision.**
  Without doing so, we stand to threaten any hope of meaningful progress on societal health and economic goals and will continue to face the devastating, uneven and unfair impacts of threats like covid-19. Driving a shared, forward-looking vision around what achieving health equity looks like is critical to success.

## Identifying the barriers that can stand in the way and how to overcome them:

- **Stakeholders and systems can either perpetuate or address disparities.**
  Inaction can be as powerful as action. This research lays out a clear route for various stakeholders to contribute to the pursuit of health equity, and systems for accountability and measuring progress should be implemented to encourage them to do so.

- **Systems are slow to promote equity because they are often incentivised not to.**
  Currently, in both the US and UK health systems, incentives for health and social care are often set up to perpetuate disparities. With a greater focus on equity-centred performance and targets, stakeholders and systems are more likely to both reduce disparities and achieve efficiency.

This research has taken a systematic and pragmatic approach to creating a vision of health equity, using 2040 as a reference timeframe. To take us from words to action, we offer many avenues to address health disparities in our focus health areas of HIV and STIs, mental health, and covid-19 and beyond, by defining current drivers of disparities, exploring what health equity could look like in the future and defining clear steps for specific stakeholders to take to get there. In doing this, we stand the best chance of limiting the impact of threats like covid-19 and create a critical blueprint for driving healthier, more inclusive, economically viable and successful societies.

To do so, we have identified the pervasive, negative impact that disparities have, not just on health, but also on the ability of people to live full lives, whatever that might mean to each of us. This gives us the "why" to make the case for action on health disparities. Similarly, we have identified what it means to achieve health equity in areas commonly affected by disparities like HIV and other STIs, mental health and covid-19. This tells us "what" needs to happen. Then to solidify our vision of health equity, we have defined "who needs to do what" within a defined ecosystem of stakeholders to get us there.

In this report we highlight the impact of health disparities, identify the key stakeholders who need to take action and elaborate on the concrete actions that they can take to address disparities. Combined, this creates both an impetus and direction for action on health disparities, to address this historic lack of action.

**" Reports get commissioned and recommendations get made. But they're not systematically and vigorously implemented – that's the problem. Then a decade or so later, another report gets commissioned and we're stuck in this cycle."**

Liz Sayce
Chair of the Commission for Equality in Mental Health,
hosted by the Centre for Mental Health

# Appendix 1: About this report

*Achieving health equity: a roadmap to eliminating disparities* is a report by Economist Impact (EI) exploring what the future could look like if disparities were addressed and what actions will be needed to ensure this happens. Health disparities are defined as avoidable, unfair and systematic differences in the health of people in particular groups. Using that definition, while capitalising on the gaps exposed by covid-19, Economist Impact sought to offer a unique perspective by bringing this seemingly intractable issue to a more tangible, and therefore actionable, level. The aim of this research was to develop a framework for action that is forward-looking, holistic and truly effective. To do so, we have approached our research and analysis from two primary angles: taking a stakeholder-based perspective to analysis and grounding this work in a future-facing view.

Inputs to this analysis included an expansive literature review, a series of interviews with experts in the field and in-depth data analysis around disparities, focusing on the US and UK. Several key experts and stakeholders were engaged in the process. To note, the findings and views expressed in this report are those of Economist Impact and do not necessarily reflect the views of these contributors or sponsor. We extend our sincere appreciation to the following for their time and contributions to this work:

- **Vanessa Apea**
  Consultant Physician in Genito-urinary and HIV medicine and Clinical Lead for Sexual Health, Barts Health NHS Trust, UK
- **Lisa Fitzpatrick**
  Founder, Grapevine Health; clinical professor at George Washington University School of Medicine, US
- **Angela Kimball**
  National Director, Government Relations, Policy and Advocacy, National Alliance on Mental Illness, US
- **Melissa Marx**
  Assistant Professor, Department of International Health, the Johns Hopkins Bloomberg School of Public Health, US
- **Homero E. del Pino**
  Associate Professor, Charles R. Drew University of Medicine and Science, US
- **Ibidun Fakoya**
  Research Fellow, King's College London, UK
- **Liz Sayce**
  Chair of the Commission for Equality in Mental Health, hosted by the Centre for Mental Health, UK
- **Kelly Thompson**
  Policy Analyst, Research & Evaluation Group at Public Health Management Corporation, US

In addition, various stakeholders who are not listed here are thanked for their contributions, referrals to experts and other resources in the space. This work was sponsored by ViiV Healthcare and conducted by Economist Impact. The research was led by Amanda Stucke and Elly Vaughan, with analysis led by Taylor Puhl and assisted by Towo Babayemi and Anoop Menon. The literature review was conducted by Sarah Greenley. The report was written by Paul Tucker, and edited by Janet Clapton, Amanda Stucke, Elly Vaughan and Taylor Puhl.

This report is accompanied by two in-depth case studies. The first discusses the role of health disparities as a barrier to achieving key health targets with a focus on HIV/AIDS, and the second explores the role of incentives in driving health equity among various stakeholder groups.

## About Economist Impact

Economist Impact combines the rigour of a think-tank with the creativity of a media brand to engage a globally influential audience. We believe that evidence-based insights can open debate, broaden perspectives and catalyse progress.

The services offered by Economist Impact previously existed within The Economist Group as separate entities, including EIU Thought Leadership, EIU Public Policy, EIU Health Policy, Economist Events, EBrandConnect and SignalNoise. We are building on a 75 year track record of analysis across 205 countries

Along with framework design, benchmarking, economic and social impact analysis, forecasting and scenario modelling, we provide creative storytelling, events expertise, design-thinking solutions and market-leading media products, making Economist Impact uniquely positioned to deliver measurable outcomes to our clients.

# Appendix 2: Top-level comparison of UK and US health systems

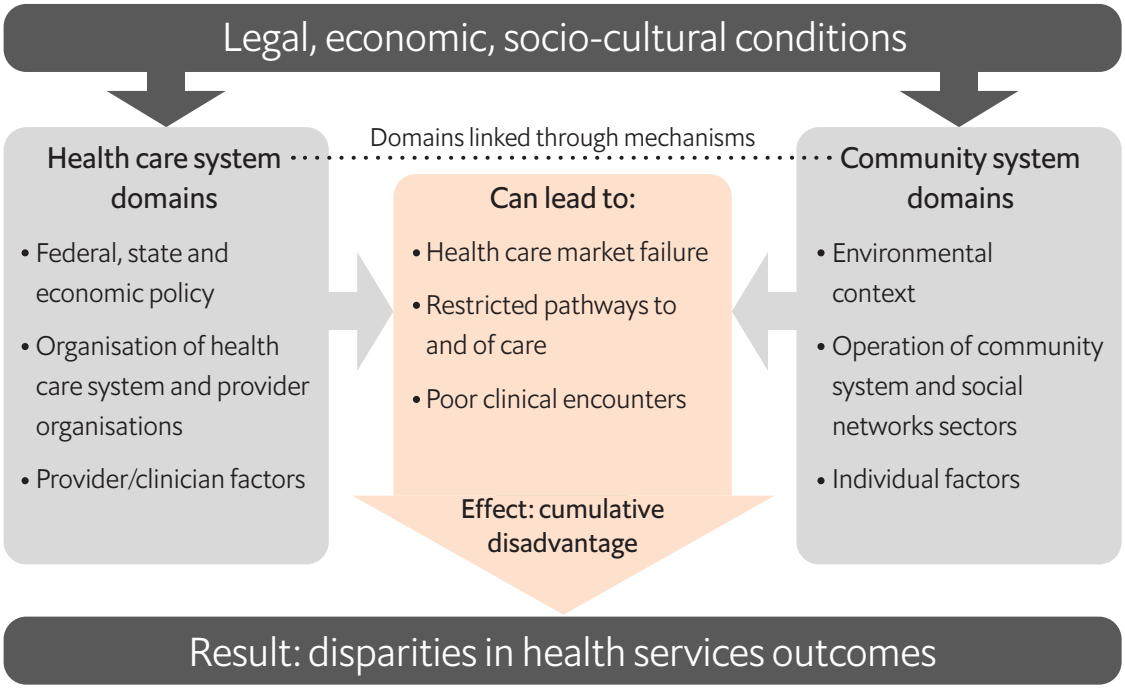
Table 3: Comparison of US and UK Health Systems

| | United States | United Kingdom |
|---|---|---|
| Funding | • Medicare (65+, some disabled)<br>• Medicaid (some low income)<br>• State-level exchange for those without employer coverage (includes income-based subsidies)<br>• Insurance coverage is mandated with exceptions (10.4% adults uninsured)<br>• Shared responsibility between government, employers and individuals for access to insurance; coverage remains fragmented<br>• Private insurance regulated mostly at the state level | • NHS utilises universal health coverage<br>• Health legislation and general policy responsibility lie with Parliament, the Secretary of State for Health, and the Department of Health and Social Care |
| Public system financing | Medicare<br>• Payroll tax, premiums, federal tax revenue<br>Medicaid<br>• Federal and state tax revenue | • General tax revenue (including employment-related insurance contributions), other minor sources such as co-payments or people using NHS services as private patients |
| Role of private insurance | • Private voluntary insurance covers 66% of population (employer based and individual)<br>• Private supplemental insurance available for Medicare recipients | • 11% purchase supplemental coverage for more rapid and convenient access (including elective treatment in private hospitals) |
| Provider payment | Primary care<br>• Most FFS with some capitation on private plans, some incentive payments<br><br>Hospital<br>• Mostly per diem and case-based payments (usually doesn't include physician costs) | Primary care<br>• Mostly a mix of capitation/FFS/P4P salary payments for a minority of people (salaried GPs are typically employees of private group practices not of NHS)<br>Hospital<br>• Mainly case-based payments (60%) + budgets for mental health, education, research and training. All include physician costs, drug costs, etc. |

Key: NHS = National Health Service; FFS = fee-for-service; P4P = pay-for-performance; GP = general practitioner

# Appendix 3: Non-health related drivers of health disparities

Figure 8: Socio-cultural framework for the study of health service disparities




Source: adapted from Alegria M, Pescosolido BA, Williams S, et al. Culture, race/ethnicity and disparities: Fleshing out the socio-cultural framework for health services disparities. Handbook of the sociology of health, illness, and healing. Springer: New York, NY: Springer; 2011. 363-382.

**Social determinants of health** are key drivers of health disparities. These include: income, access to social protection, employment status and job security, housing and environment, education, social inclusion (and conversely discrimination), and access to adequate healthcare.[4] Combined, these factors affect the ability of people to make key decisions and take necessary, timely actions, including in relation to their health. "If you're working three jobs," adds Ibidun Fakoya, a Research Fellow in the Department of Population Health Sciences at King's College London, "when do you have time to undergo an HIV test? When do you have time to respond to being sick?"

**Stigma and discrimination** also play a major role in creating and enforcing disparities. Those most at risk of HIV, for example, also face discrimination within their communities. This includes discrimination from health and non-health authorities, employers, researchers and healthcare providers, based on their actual or perceived health status, lifestyle, race and ethnicity, socioeconomic status, age, sex, sexual orientation and gender identity, among other factors. According to UNAIDS, in 35% of countries with available data, over 50% of people report having discriminatory attitudes towards those living with HIV.[61] People with mental health problems can experience discrimination in all aspects of their lives, both in wider society and from families, friends and employers. According to the Mental Health Foundation, a UK-based charity, almost 90% of people with mental health problems say that they are affected by stigma and discrimination.[62]

**Mistrust of health services** and other authority groups often further broadens the divide between health services and those supposedly served by those services. In terms of the mistrust of health services among those facing disparities, the causes include awareness of historical mistreatment in medical studies and care, personal experiences of prejudice at the hands of healthcare providers, and awareness of systemic biases in health systems.[63] Similarly, medical mistrust can also be influenced by mistrust of authorities more generally. Ultimately, lack of trust weakens the link between health services and a sizeable portion of the people who they are tasked with serving, leading to underutilisation of services and worse overall health outcomes (and a perpetuated sense of not being cared for).[64]

# Appendix 4: Detailing the past, present and future forces: foresight analysis

### Box 1: Foresight: past, present and future forces

Foresight approaches are increasingly used in policy circles to explore more proactive and agile decision-making that takes into account trends and opportunities that are often missed by short-term thinkers. This research has used an integrated approach to identify actions to address gaps and opportunities across three selected disease areas as determined by the push and pull of past, present and future forces. These forces are detailed below and shed light on how the future scenarios in the report were formed and the actions needed to get there.

**Past forces:**
What inspiration can we find from the past?
What narratives or experiences might constrain our thinking?

**Present forces:**
What forces in the present will shape the future?
Which of today's structures and systems will remain?

**Future forces:**
What are our images of the future?
What are our hopes and fears about the future?

## Past forces: What inspiration can we find from the past? What narratives might constrain our thinking?

Perhaps the most frustrating barrier, given that many people must overcome the impact of multiple disparities before they are even able to engage with health services, is the existence of stigma, discrimination and negative attitudes among clinical and care staff. This can manifest around the

intersection of paternalism and institutional prejudice, where assumptions are made about lifestyle and health-related behaviours, but where judgement can also be clouded on issues such as diagnosis. Liz Sayce, Chair of the Commission for Equality in Mental Health, cites "diagnostic overshadowing", whereby decisions on care are clouded by assumptions made based on a person's background. For example, a patient with anxiety or depression presenting with palpitations might not be put forward for the same cardiovascular diagnostic tests as another patient.

Social deprivation underlies most disparities, and the impacts on health are clear. For example, data compiled by the Health Foundation, a UK charity, show that only 50% of people aged 55-59 report good health in the most deprived areas of England, the same level as reported by those aged 80-85 in the least deprived.[65] "We have huge issues around poverty, people relying on food banks and so on," says Liz Sayce. "So, the social determinants of health go on and on."

While obvious factors such as low incomes feed deprivation, the broader environment in deprived areas is just as important. For example, England's poorest neighbourhoods have a lower average density of community space, and of cultural, educational, sport and leisure, and green assets, reducing the opportunity for people to socialise, learn, exercise, or spend time outside home or work. In essence, this reduces the opportunities for people to look after their health and welfare.[66]

Ibidun Fakoya thinks that a step further would be to understand why significant sections of the population are resistant to efforts to improve equality (for example, polling data in the UK showed support for increased welfare spending, potentially linked to tax increases, falling from 55% in 1987 to 27% in 2009). "It'd be nice to see some research that unpicked why," she says.

The fight against racism and ethnic discrimination goes on. The US civil rights movement as most people understand it—or understood it until recently—took place in the mid-1950s to late 1960s. Yet, the struggle for racial equality goes on, both in the US and the UK. In the UK, for example, a report commissioned by the UK Government claimed in April 2021 that institutional racism does not exist in the country (the report was rejected by many experts and described as "reprehensible" by the UN).[67,68] Arguably, the eruption of protests worldwide in 2020 against police violence and racial discrimination represented the largest manifestation of civil rights demands since the late 1960s.

Considering that the UK and US are both among the wealthiest countries in the world, the mismatch between health demand, funding and access to care can be daunting. "The attachment of health insurance to employment is extremely problematic when we think about the lack of safety net, and a lack of access to employment—things that are often out of folks' control—because they relate to all of these social determinants of health that we've been talking about," says Kelly Thompson. In a wider sense, the social support available to people does not always plug the gaps, and it will struggle to do so even more as governments seek to recover from the economic impact of covid-19.

## Present forces: What forces in the present will shape the future? Which of today's structures and systems will be influential?

Surprisingly, given the resources and knowledge available in the US and UK health systems, the collection, analysis and use of data is often suboptimal, even as increased data and monitoring capabilities become available. Demographic data can also lack the level of segmentation that would provide a nuanced picture of the patients using services. For example, the assessment of racial disparities in sweeping categories such as "BAME" in the UK or "Hispanic" in the US disguises nuanced disparities.

Beyond simple issues such as the use of sweeping labels, the discrimination of the past continues to play out today, including among individual healthcare workers and on a broader, institutional level. Increased awareness of discrimination and disparities has led calls for unconscious bias and diversity training; but challenges remain when it comes to efficacy. Discrimination, including among health workers, says Kelly Thompson, must be eliminated on a systemic level. "I think training for clinicians and service providers around historical inequity and discrimination, and how to properly address those things, how to understand bias, racism, unconscious bias would do a lot to address the disparities that we see in mental health, STDs, etcetera."

In addition to ground-level issues of discrimination, bias exists in provision among providers and insurers, especially in relation to mental health care. Angela Kimball points to the fact that states wanting to divert funding from inpatient to community-based services cannot claim cost neutrality in the Medicaid program because the former are not covered by Medicaid. "So, it's this perverse, economic disincentive to actually provide the very community-based services that we want," says Angela Kimball. In addition, she points to "insidious" biases in insurance plans that treat mental health and substance use conditions differently.

## Future forces: What are our images of the future? What are our hopes and fears about the future?

Amid the growing awareness of disparity regarding race and ethnicity, gender, age and social deprivation, people have become more vocal about the need to rectify such problems. Given this, pressures will continue to increase on the public and private sectors to take a stand on health disparities and deprivation, and particularly on policymakers, researchers, insurers and providers because of vocal demands for health reform.

One area of action involving providers and researchers is workforce diversity. The experts that we spoke to echoed each other in saying that minority representation is a key absence. As with elsewhere,

demands and action to increase the diversity of the workforce will have an impact, and the diversity of health workers should rise, especially in more senior roles.

The point that action must be taken in areas such as workforce diversity links to a key note of optimism: health disparities are avoidable, and so they can be reversed. "When you talk about any structural difference, it is that fact that it's systematic, unjust and avoidable that gives us something that we can and must definitely act on to change," says Vanessa Apea.

Although it should be clear that patients are not responsible for disparities in any area of their own care, the increased involvement of ordinary people is a vital step in this reversal of disparities. Put simply, the evolving role of patients and their families, friends and community leaders, will increase empowerment and engagement. In both the US and the UK, the advancement of integrated healthcare, with a focus on prevention and community-based care, places patient-centred care at the heart of delivery. In the UK, the mantra used is "no decision about me without me."[69] Moves to ensure that care is patient-centred are in place, if sometimes imperfectly implemented while attention is also being paid already to increasing engagement with the communities of people traditionally facing disparities.

Homero E. del Pino points to the influential role that community leaders, families and peers can have in validating and advocating for aspects such as prevention and treatment for conditions like HIV. His experience suggests making use of social networks, such as family members, and organisations such as churches and community groups to raise awareness of HIV-related issues. He pointed out, "What people tend to ignore is the longitudinal nature of relationships, [that] people reconcile over time, they are happy to get their gay brother or son or caretaker back into the family." Ignoring these crucial support systems not only risks undermining progress at reducing disparities but will continue to slow advancement toward this goal.

For all stakeholder groups, especially at every level of service provision, good data collection, analysis and usage is going to be a vital area of improvement. Although there are problems with regards to data collection and analysis, advances in data analytics platforms and activities may bring about improvements in tracking disparities and providing incentives for good practice and quality improvement. Angela Kimball points to a programme at the Oregon Health Authority that used data analytics to track progress on programme improvement initiatives, with financial rewards (in terms of budget) as an incentive for success. "It became a learning community, based on transparent public data collection, with real dollars, big dollars attached; there was real impetus to improve quality." This is one example of how data can be used to realign incentives and increase service quality.

Alongside these future forces, there are several other megatrends that could impact on the delivery of the vision of health equity (see Box 2).

## Box 2: Megatrends that may impact on achieving health equity

### Ageing.
Population ageing is underway in low-, middle- and high-income countries globally. The UK and US are no different: it is projected that by 2040 nearly one in seven people in the UK will be aged over 75, while more than one in five Americans will be over 65, up from about one in eight in 2000.[70,71]

### Urbanisation.
As people increasingly move to cities, they will require services that cater to more dense populations, while rural care will require innovation—such as telehealth-based delivery—to expand access and maintain sustainability. This pattern may be disrupted by covid-19, but is still expected to hold true in the longer term.

### Digital Divide.
The growing sophistication and penetration of technology in everyday life (as well as in healthcare delivery) will require innovation in addressing the digital divide and bias that may arise from it. For example, A 2020 report estimated that 9m people in the UK (16% of the population) cannot undertake activities such as turning on a device, connecting to Wi-Fi or opening an app by themselves.[72] Evidence also suggests that the most vulnerable and disadvantaged are the most likely to be digitally excluded. Older age, particularly when coupled with minority backgrounds, has been identified as the biggest indicator of low digital engagement.[73]

### Climate.
A focus on climate will be a stronger driver of decision-making, while the impacts of climate change may also increase disparities in some areas.

### Healthcare.
Shifts in healthcare away from treatment and toward predicting, diagnosing and monitoring will require preventive models that do not perpetuate disparities. This will require greater recognition of the linkages between health and wealth.

### Economies.
The UK and US economies have been hit hard by the impacts of covid-19. Already-stretched health and social spending will come under even more pressure as governments look to make up lost ground in terms of economic growth and public finances in the wake of covid-19.

### Legal challenges.
Rapidly changing landscapes in areas including technology and healthcare models will raise new ethical challenges in areas such as data privacy and regulatory frameworks.

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