

## Bridging the global health gap



If there is one constant in the evolving global health agenda, it is the need to address disparities in health. The often-made distinction between inequality and inequity is important: the former simply describes a difference between two measurements of the same indicator, while the latter includes the notion that this difference is unjust or wrong. Whatever the term used, the endpoint is the same: there are notable variations in health outcomes between population groups, and one of the goals of global health practitioners is to reduce them.

Since the middle of the 20th century, national governments and international organisations have committed to eliminating the gap between the most and least disadvantaged. Researchers in global health have been exploring and outlining these differences and policy makers have used the data to attempt to reduce inequalities and inequities, with some measure of success both in high-income and low-income and middle-income countries (LMICs). Yet despite these efforts, disparities linger. Within countries, social groups still present substantially different levels of health indicators. And differences in fundamentals such as life expectancy, mortality, prevalence of diseases, or access to health services illustrate the persistent chasm between countries. In this issue of *The Lancet Global Health*, three studies provide examples of the permanence of these imbalances in the global health panorama at multiple levels.

Looking at mortality trends in South Africa over several years, Victoria Pillay-Van Wyk and colleagues show the influence of complex social factors on differentials in mortality within the country. Despite the declines in deaths from HIV, non-communicable diseases, and injury, all cause age-standardised death rates were still 2.2 times higher in black South Africans than in white South Africans in 2012, and 1.4 times higher in women than men. In another Article, Martyn Plummer and colleagues present the latest global picture of cancers attributable to infections. 15.4% of cancers worldwide were estimated to be attributable to infections in 2012, and two-thirds of these largely preventable causes occurred in less developed countries, where they are associated with one in four cancers. Finally, in an assessment of coverage of three doses of diphtheria-tetanus-pertussis (DTP3) immunisation in LMICs, Ahmad Hosseinpoor

and colleagues find large differences in coverage across countries (from 32% to 98%) as well as within countries, where the richest stratum of the population usually benefits from the highest coverage.

Well designed studies such as these are needed to act on inequalities—document them, monitor them, and prioritise limited resources to those most in need. But seeing the permanence of this type of conclusion, the impatient global health observer cannot help but wonder why all the knowledge and discourse on inequalities and inequities have not led to their quicker and more effective reduction. Clearly, as the focus on the social determinants of health has shown in the past, the underlying causes of inequities and inequalities are complex and go beyond the remit of the health sector. But could global health practitioners adjust the way they address these issues to reach better results?

There are two proposals to initiate a focus shift in this month's issue. In a Comment, Margaret Kruk and colleagues call for a "quality revolution in global health", noting among other things that quality of care has been neglected in global target setting. Yet without quality, increasing access to health services is a futile effort that will not help reduce health differentials. Commenting on the trends in DTP3 coverage, Enrique Delamónica highlights the well recognised need to move beyond aggregated data to clarify and disentangle the many factors that generate inequalities in the first place, and identify those out of reach. However, he takes this idea to the next level by suggesting that this understanding of the neglected must be incorporated into the way health targets, such as immunisation coverage, are set. Percentage targets should be sensitive to whom is implicitly being left out, he states. In essence, the message in both cases is that equity should go beyond being just a concept and become a tool to be used to improve health planning and drive the nature of health services.

With the inclusion of a goal entirely dedicated to equality in the Sustainable Development Goals (SDG 10), the development community—with global health practitioners at its core—seems to have been given a whole new toolbox to work with. Let us hope it proves adept at using it. ■ *The Lancet Global Health*

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