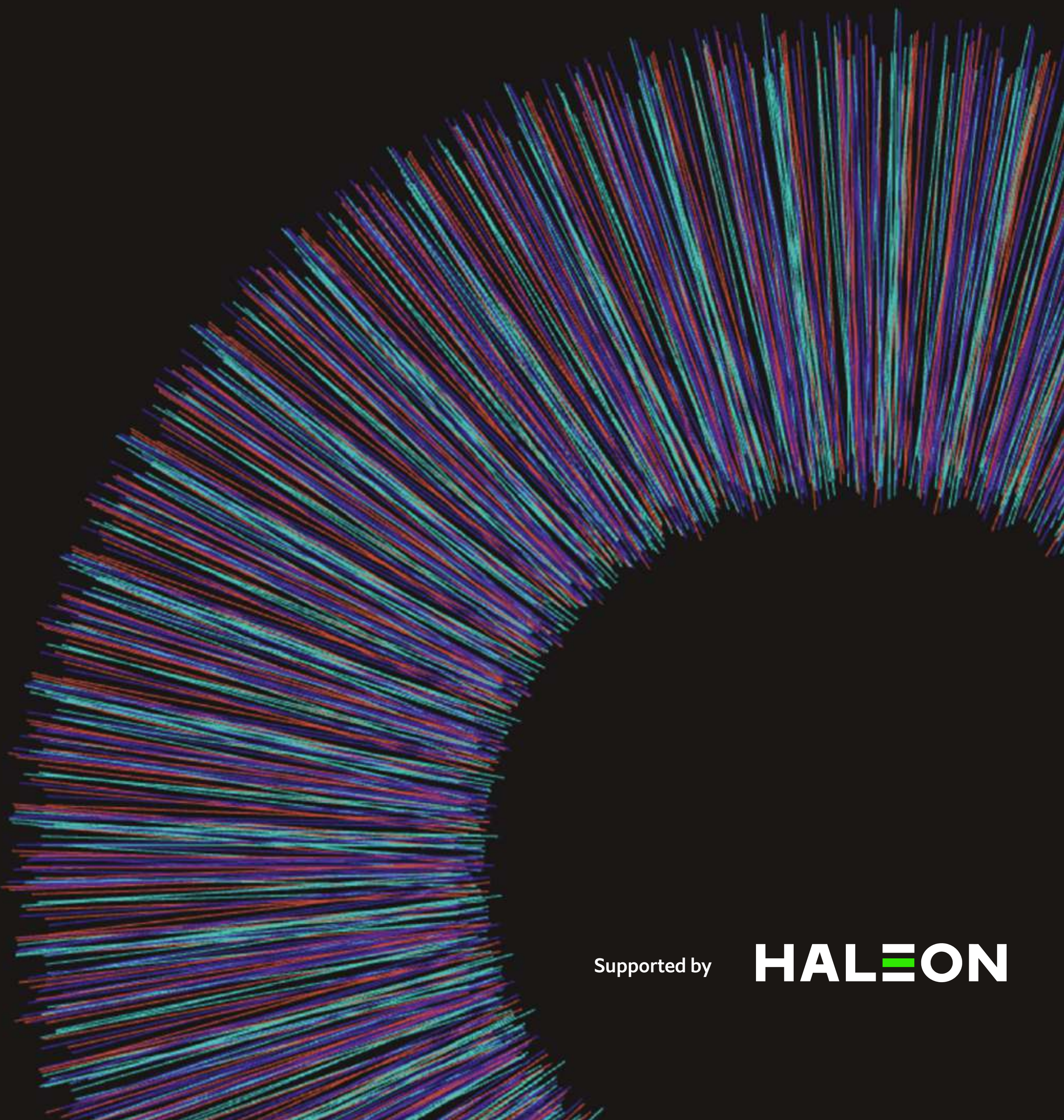
ECONOMIST IMPACT

The Road to Health Inclusivity: from policy to practice

Findings from the second phase of the Health Inclusivity Index



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About the report

This report is based on the findings of the second phase of the Health Inclusivity Index, developed by Economist Impact. The report and research are supported by Haleon.

This research and analysis proceeded from the view that *all* members of society should have equal and unrestricted opportunities for accessing good physical, mental and social health and wellbeing. The first phase of the Health Inclusivity Index, launched in 2022, was designed to gauge country-level efforts at ensuring these opportunities through the assessment of national policy and key healthcare infrastructure. It provided the first ever snapshot assessing the state of health inclusivity across 40 countries. It assessed the level of health inclusivity in national policies, systems and at the community level, measured against every person's opportunity to optimise their health.

The second phase of the Index builds on these findings with the addition of new measures to assess whether inclusive health policies at the national level are translating into lived experience at the community level. To achieve this, Economist Impact conducted a global survey with over 42,000 individuals across the selected countries to gather insights about barriers and experiences while obtaining healthcare and maintaining good health.

This white paper presents the findings from our research and explores what they reveal about the global state of health inclusivity—and exclusion—in policy and in practice. The paper highlights four key themes that emerged through our research and concludes with a series of actions and practical solutions that can be taken by different stakeholders to drive health inclusivity in society as a whole.

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Foreword

Health inclusivity is the linchpin for creating fair and equitable societies. The aim to truly remove the "personal, social, cultural and political barriers that prevent individuals and communities from experiencing good physical, mental and social health, and live a life fully realised", has never resonated as much as it does today. As we write this foreword, we do so against a backdrop of ongoing and increasingly worsening disparities in health outcomes. Those disparities are driven by multiple factors, including health access issues related to the aftermath of the Covid-19 pandemic; the cost of living crisis that threatens access to quality housing and long-term food security for many; as well as geopolitical conflict, which has increased the number of global refugees and asylum seekers.

The inaugural Health Inclusivity Index (HII) in 2022 offered an unprecedented, data-driven framework to assess health inclusivity across 40 nations. It established a solid baseline to benchmark global and local progress against, and scrutinised national policies to pinpoint areas ripe for development. The key findings from Phase 1 emphasised the importance of people and community empowerment in improving health inclusivity, with eight of the 10 highest-scoring countries performing strongly in this domain. Phase 1 also revealed a convincing correlation between healthy life expectancy and health inclusivity and a surprisingly weak correlation between health spend and health inclusivity. These findings have helped to refocus policymaker attention on both the importance and cost effectiveness of people and community empowerment as a means to improve health inclusivity. Case studies then provided further insight into good practise in this area.

In its latest iteration, the HII has gone beyond updating its framework and data. Fulfilling its inherent commitment to inclusivity, the Index now integrates the perspectives of those it seeks to serve—countries' citizens. We are excited to see that the lived experiences of 42,000 survey respondents from all 40 index countries, as well as in-person interview participants in seven 'deep-dive' locations have been included in the analysis. This expansion is methodologically rigorous and crucial to generating actionable, 'real-life' insights, since it is the combination of policy and practice that determines whether countries are not only designing for inclusivity but actually delivering it for their citizens.

Perhaps not surprisingly, this inclusion of citizens' views has led to some, at times quite dramatic, changes in rankings from last year—a reminder that we must be vigilant in our understanding of health inclusivity. It is not a static entity. Notably, integrating citizen feedback has prompted significant shifts in country rankings, illustrating the dynamic nature of health inclusivity and the need for continual reassessment.

A key finding in this year's report is the persisting disparity between policy and practice, particularly in high-income countries. This gap underscores a harsh truth: well-intentioned policies do not automatically translate into positive health outcomes. At the same time, it is encouraging to have our evidence confirm that many low- to middle-income countries bridge this divide effectively, despite limited resources and infrastructural constraints. As the report aptly puts it: "By finding ways to deliver services in communities from the bottom-up as well as the top-down, more countries can make more effective use of their health investment and deliver on their promises for inclusion. Making health services available in communities is an effective way to include people in vulnerable and marginalised populations".

The report also calls out that there are groups of people across the globe who experience significant and systemic barriers to achieving everyday health. Not only does it highlight the need for empowering individuals and communities to strengthen their health literacy and agency, it also highlights the need for a one-health approach to removing the barriers that stand in the way for good health and wellbeing.

The second phase of the HII has brought to light several critical issues that can help focus actions to improve health inclusivity:

- People in marginalised populations and people with chronic health conditions are far more likely to encounter healthcare access and discrimination barriers.
- While nominally available, health services are often practically inaccessible, with more than three in five individuals facing obstacles to essential services.
- A generational schism within global health systems is failing younger populations, especially Gen-Z, who disproportionately suffer from exclusion.
- Women continue to struggle with accessing necessary health services and information, with the lack of available appointments being a significant hurdle.

Emphasising inclusivity is crucial for improving the health and well-being of individuals and communities. It affirms the inherent value of each individual, honouring their autonomy and agency. Thinking inclusively, therefore, accepts and takes into account the lived experiences of human beings and invites us not only to ask what closes the gap between differences in our biological and socio-economic realities, but to understand and rectify the ways in which people are excluded, disempowered and rendered invisible.

Health is not a zero-sum game. At a time when most healthcare systems are under significant strain and struggling to balance cost with access to high-quality service delivery for all, health inclusivity is the key to a more equitable, fair and resilient health-care system. This objective must be taken up by policy makers, public health experts, health systems actors, community stakeholders and businesses.

There is no simple algorithm for health inclusivity, which is why adding country experiences with a stronger focus on outcomes is a key step towards improving the usefulness of this report as a practical tool for policy makers and others to strengthen health inclusivity in their settings. To continuously inspire evidence-based multi-stakeholder action to drive change, and truly understand how to promote the web of interconnected drivers for health inclusivity, we are simultaneously working on building a catalogue of best practice examples for health inclusivity, and welcome the continued dialogue with fellow health inclusivity champions.

Let the insights of this pivotal report galvanise us to foster a culture that recognises and appreciates the richness of diversity, inviting actionable changes that uplift everyone, regardless of their background.

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Executive summary

Health is foundational to almost every aspect of our lives. It impacts our ability to learn, work, communicate and form connections. Good health extends beyond the absence of illness, encompassing access to and enjoyment of physical, mental and social wellbeing. Conversely, poor health puts stress on individuals, communities, systems and countries, demanding resources and curtailing growth. In short, healthy individuals support thriving societies.

Yet, the capacity of individuals to achieve good health is often inconsistent and unequal, both across and within countries. Significant disparities exist between individuals' access to essential health systems and the quality of treatment and services received. Furthermore, inequitable access to the core building blocks of good health—such as education, housing and healthy food—can also lead to disproportionately worse health outcomes or impede individuals' attempts to manage and improve their health.[1] The most vulnerable or marginalised groups often bear the brunt of these imbalances.

We define "health inclusivity" as the process of removing the personal, social, cultural and political barriers that prevent individuals and communities from experiencing good physical, mental and social health, and a life fully realised.

Designing more inclusive approaches to health necessitates the introduction and implementation of targeted and effective policy measures that address the underlying causes of health disparities and exclusion. Services must be available, accessible, easy to navigate, affordable and of decent quality. To ensure policy measures deliver in practice, we need to understand the lived experience of the communities they are designed to serve and identify where policies are effective and where individuals continue to face barriers when accessing and interacting with health systems.

Economist Impact's Health Inclusivity Index, supported by Haleon, assesses governments' efforts worldwide to ensure that good health is accessible to all individuals. The Index utilises over 50 individual indicators across three domains to evaluate the health inclusivity policy landscape, the availability of key systems and infrastructure, and efforts to empower individuals and communities to navigate health systems and take care of their own health.

The first phase of the Index, released in 2022, assessed 40 countries against these metrics. The second phase of the Index incorporates additional indicators, developed from a survey of over 42,000 adults across the Index countries, that capture lived experience and measure the implementation and outcomes of policy. In other words, the second phase measures not only whether countries are designing policy that supports health inclusivity, but also are delivering it effectively in practice.

Key findings

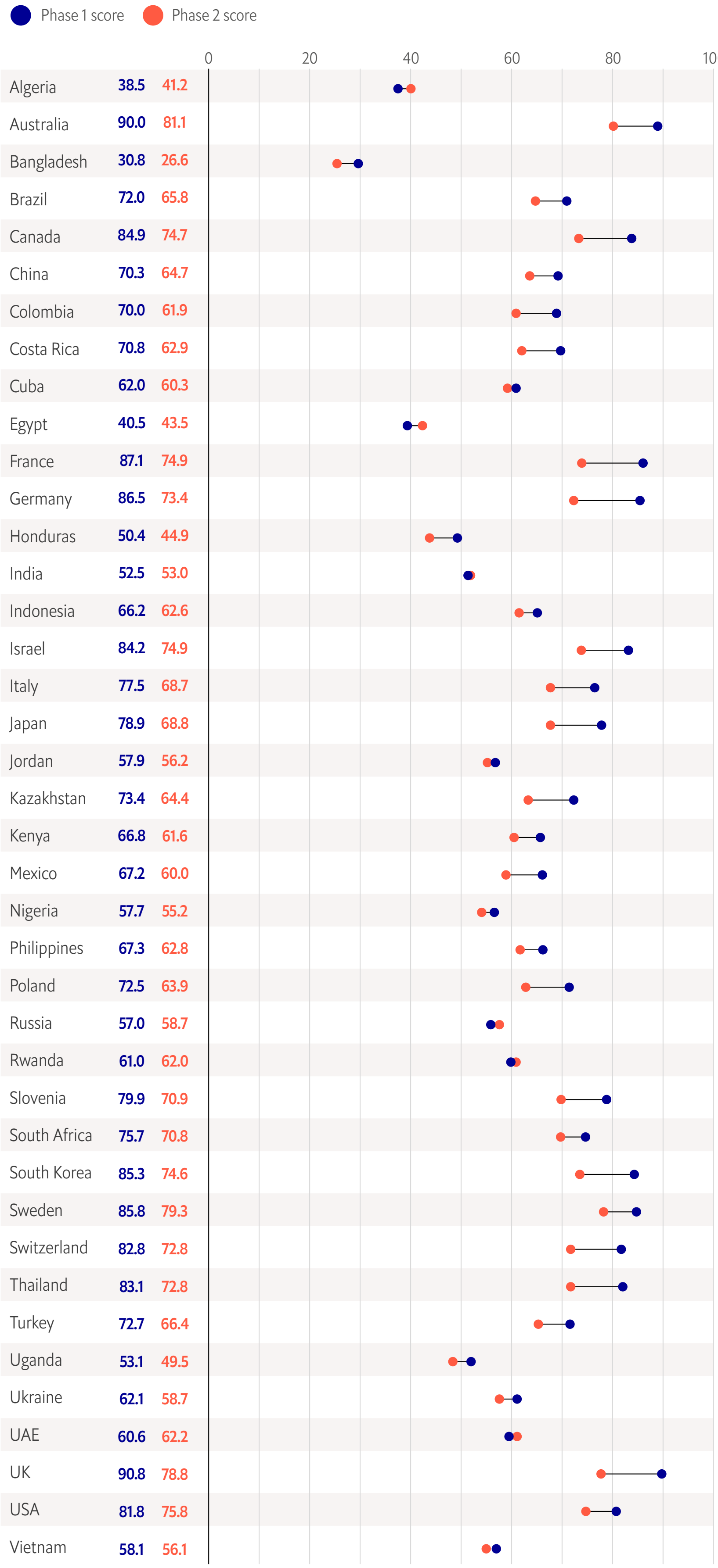
There is a clear gap between policy and implementation:

85% of countries' inclusivity scores deteriorated between phase 1 and phase 2. Effective and inclusive health systems require the enactment of strong policy frameworks *and* the meaningful implementation of these measures in practice. Through a survey of over 42,000 individuals across the countries included in the Index, Economist Impact added a set of indicators that measure population-level experiences and implementation to provide a more enhanced measure of health inclusivity. These indicators also show that individuals' experiences of health inclusivity are not meeting the standards established in policy. **While a strong policy backbone is a foundation for health inclusivity, it is the effective and inclusive implementation of these policies that will reduce inequities and improve health outcomes for populations.**

Australia and Sweden surpass the UK as the most health inclusive countries when population experiences are integrated into the Health Inclusivity Index.

Figure 1: Change in country scores after incorporating population experiences

Phase 1 scores compared to Phase 2



	Phase 1 score	Phase 2 score
Algeria	38.5	41.2
Australia	90.0	81.1
Bangladesh	30.8	26.6
Brazil	72.0	65.8
Canada	84.9	74.7
China	70.3	64.7
Colombia	70.0	61.9
Costa Rica	70.8	62.9
Cuba	62.0	60.3
Egypt	40.5	43.5
France	87.1	74.9
Germany	86.5	73.4
Honduras	50.4	44.9
India	52.5	53.0
Indonesia	66.2	62.6
Israel	84.2	74.9
Italy	77.5	68.7
Japan	78.9	68.8
Jordan	57.9	56.2
Kazakhstan	73.4	64.4
Kenya	66.8	61.6
Mexico	67.2	60.0
Nigeria	57.7	55.2
Philippines	67.3	62.8
Poland	72.5	63.9
Russia	57.0	58.7
Rwanda	61.0	62.0
Slovenia	79.9	70.9
South Africa	75.7	70.8
South Korea	85.3	74.6
Sweden	85.8	79.3
Switzerland	82.8	72.8
Thailand	83.1	72.8
Turkey	72.7	66.4
Uganda	53.1	49.5
Ukraine	62.1	58.7
UAE	60.6	62.2
UK	90.8	78.8
USA	81.8	75.8
Vietnam	58.1	56.1

The Health Inclusivity Index measures countries' performance across three domains: Health in Society, Inclusive Health Systems and People and Community Empowerment.

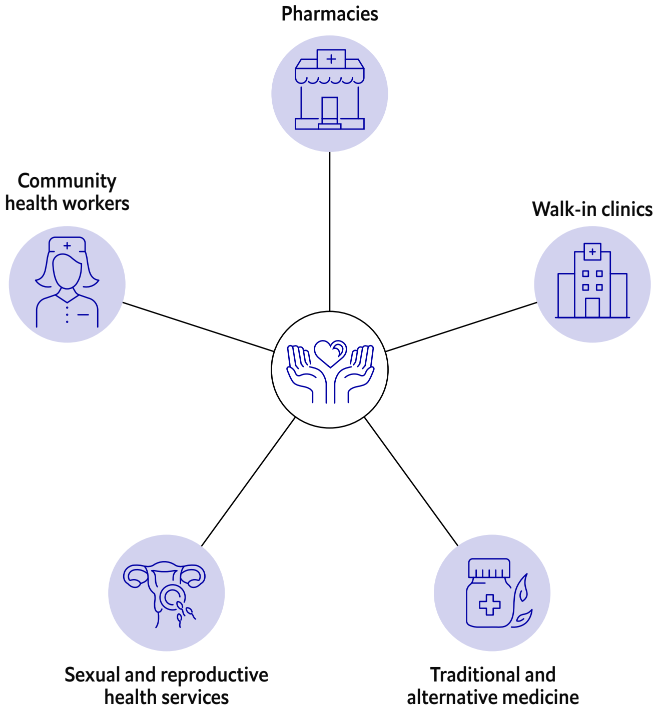
This gap is biggest in high income countries.

High-income countries in the Index have a 18-point difference between their scores on health policy indicators and on-the-ground practice indicators across the three Index domains. The UAE is the only high-income country that does not follow this trend: its population's experience of inclusion in health is more positive than the policy environment within the country would indicate. In contrast, low- and middle-income countries have an average 3-point difference between health policy indicators and implementation indicators across the three domains. **Although high-income countries have forged ahead in developing and instituting ambitious inclusion policy, this push has led to a gap in implementation, the closing of which will require focus, effort and resources.**

Community empowerment and community-based services can help countries overcome the policy-implementation gap.

Community services are a central component of inclusive health and care systems, facilitating greater access to healthcare services and information for good health. Low- and lower-middle-income countries outperform their high-income counterparts on measures around community-based healthcare services. Respondents in low- and lower-middle-income countries were almost 10 percentage points more likely to indicate that the five core community-level services assessed by the Index are available in their local area (see Figure 2). **Community health workers and community services have greater potential to reach groups at higher risk of exclusion and help to ensure that systems are both accessible and culturally appropriate to the communities that they are serving.**

Figure 2: The five core community based services assessed by the index



This gap puts vulnerable populations at greater risk of exclusion.

While 58% of countries have structures in place to guarantee access to translation services and health materials in other languages, just three in ten people (32%) report actually having access to such services in these countries. The impact of this gap can be even greater for specific vulnerable or marginalised populations. Specifically, 27% of refugees, asylum seekers or displaced persons indicated that language barriers have made it difficult to see a doctor or access other healthcare services in their community, compared to only 6% of the general population. People from marginalised populations and individuals with chronic health conditions are also more likely to be treated unfairly.[i] Over one quarter of respondents (27%) who identified as a member of these groups felt that they were discriminated against when interacting with healthcare providers, compared with 19% of non-marginalised groups, and 9 percentage points more likely to say that they have been denied tests or treatments that they believed would have been beneficial to their health (31% vs 22%). **Inequities for many marginalised or vulnerable populations are avoidable and require the implementation of targeted interventions, which should be designed in collaboration with the populations that they aim to target.**

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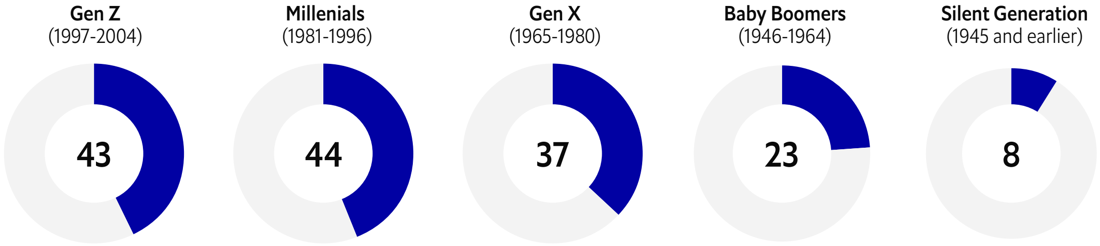
[i] When referring to "marginalised populations and people with chronic health conditions" in this study, we define these groups as: minority ethnic persons; persons with a disability; LGBTQIA+ persons; migrants; refugees, asylum seekers or displaced persons; individuals identifying as part of another minority group, and persons living with a chronic health condition/disease.

Younger respondents also face significant challenges to accessing good health.

Younger respondents are more likely to report being denied access to healthcare and to see trust and cost as barriers to receiving care. More than one in five (21%) Gen Z and Millennial respondents reported that they had been denied access to care, compared with 14% of older respondents.[ii] Younger respondents are also more likely to report that cost makes it difficult to access care (see Figure 3). Younger respondents were two times more likely than older ones to cite trust in healthcare providers as a factor making it difficult to access services, turning instead to social media as a way to access information. **Reducing these barriers and investing in young people's health can create a foundation for a healthier, more productive future that benefits individuals, communities and economies.**

Figure 3: Healthcare costs preventing healthcare access, by generation

Percentage of survey respondents experiencing healthcare costs as a barrier to healthcare access (%)

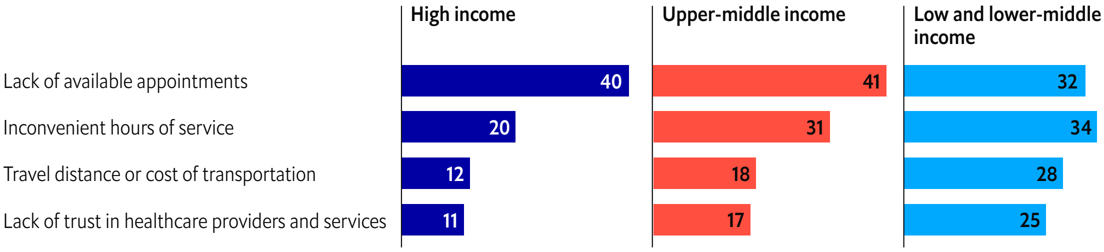


Most people globally experience barriers to accessing healthcare.

Over three in five respondents in our global health inclusivity survey experienced barriers to access. The most common of these barriers include lack of available appointments, distance and cost of travel, and lack of trust in healthcare services. The biggest barriers vary by country income level (see Figure 4). In our UK focus group discussion, one participant reported the difficulty of trying to get an appointment at a specialist clinic: "They said if I wanted an NHS appointment it could take up to six months to a year." A focus group participant in India noted that there are no clinics or doctors' offices nearby, leaving the municipal hospital as the only option for seeking care. **Healthcare must be both available and accessible to ensure proper utilisation and reduce health disparities.**

Figure 4: Greatest barriers to accessing healthcare (outside of healthcare costs), by country income group

Percentage of survey respondents experiencing the top barriers to healthcare access (%)



[ii] Respondents from Generation X, Baby Boomers and the Silent Generation.

The remainder of this report explores the findings from the Health Inclusivity Index. It showcases where progress has been made and underscores pivotal areas demanding further action. It provides governments, civil society, practitioners, communities and individuals with a toolkit for identifying existing gaps and inequalities, tracking progress, and developing more effective solutions. Ultimately, the Health Inclusivity Index aims to raise awareness and ignite global action to make good health a reality for all.

Figure 5: The development of the Health Inclusivity Index and its key findings from phase 1 to phase 2

The phase 2 Index builds on the findings in phase 1 by incorporating indicators that assess lived experience. The revised framework unpacks critical nuances around health inclusivity within and across countries, helping us to understand the extent to which policies designed to drive inclusion are delivering in practice.

Phase 1 finding	Phase 2 finding	Supporting data
Inclusivity is only part policy–without implementation, policy is meaningless	There is a clear gap between policy and implementation	85% of countries' inclusivity scores deteriorated between phase 1 and phase 2 Three in four countries have a national policy or strategy on person-centred care, but only 50% of survey respondents agree that their personal preferences are taken into account
Health inclusivity requires the identification of vulnerable populations	The policy-practice gap puts vulnerable populations at greater risk of exclusion	93% of countries have established health as a basic right for all individuals living within their territory and still, marginalised populations and individuals living with a chronic health condition are 10 percentage points more likely to report having been denied access to healthcare services than non-marginalised groups
Community and individual empowerment is at the heart of health inclusivity	Community empowerment and community-based healthcare services can help countries overcome the policy-practice gap	Just three high-income countries score in the top 10 on the implementation indicators in the People and Community Empowerment domain when lived experience is integrated

Introduction

Health inclusivity means that every individual in society has the opportunity to lead a healthy life. Ensuring that they do is challenging. Countries have taken radically different approaches to healthcare and service delivery, and diverse social and cultural norms can influence expectations and perceptions around definitions of good physical, mental and social health.[2] Furthermore, healthcare systems alone cannot guarantee good health. A range of non-medical factors, such as good quality and safe housing and education, conducive working conditions, social inclusion, and more—the social determinants of health—are known to fundamentally impact inclusion and, ultimately, health outcomes.[1]

Economist Impact's Health Inclusivity Index, supported by Haleon, is a first-of-its-kind attempt to evaluate countries' efforts to facilitate their populations' ability to lead a healthy life. It assesses the extent to which countries ensure health pervades national policies, programmes and communities, and that it reaches all members of society.

The evolution of the Health Inclusivity Index

The phase 1 Health Inclusivity Index, launched in October 2022, was the first-ever assessment of health inclusivity at a global scale. Prior to the publication of the Index, the term "health inclusivity" was referenced, but rarely defined or measured. The Index fills this gap, providing a framework for understanding and assessing efforts towards making health inclusivity—particularly health equity—a reality. The phase 1 index assessed country-level action on health inclusivity using 37 indicators grouped across three key domains: Health in Society, Inclusive Health Systems, and People and Community Empowerment.

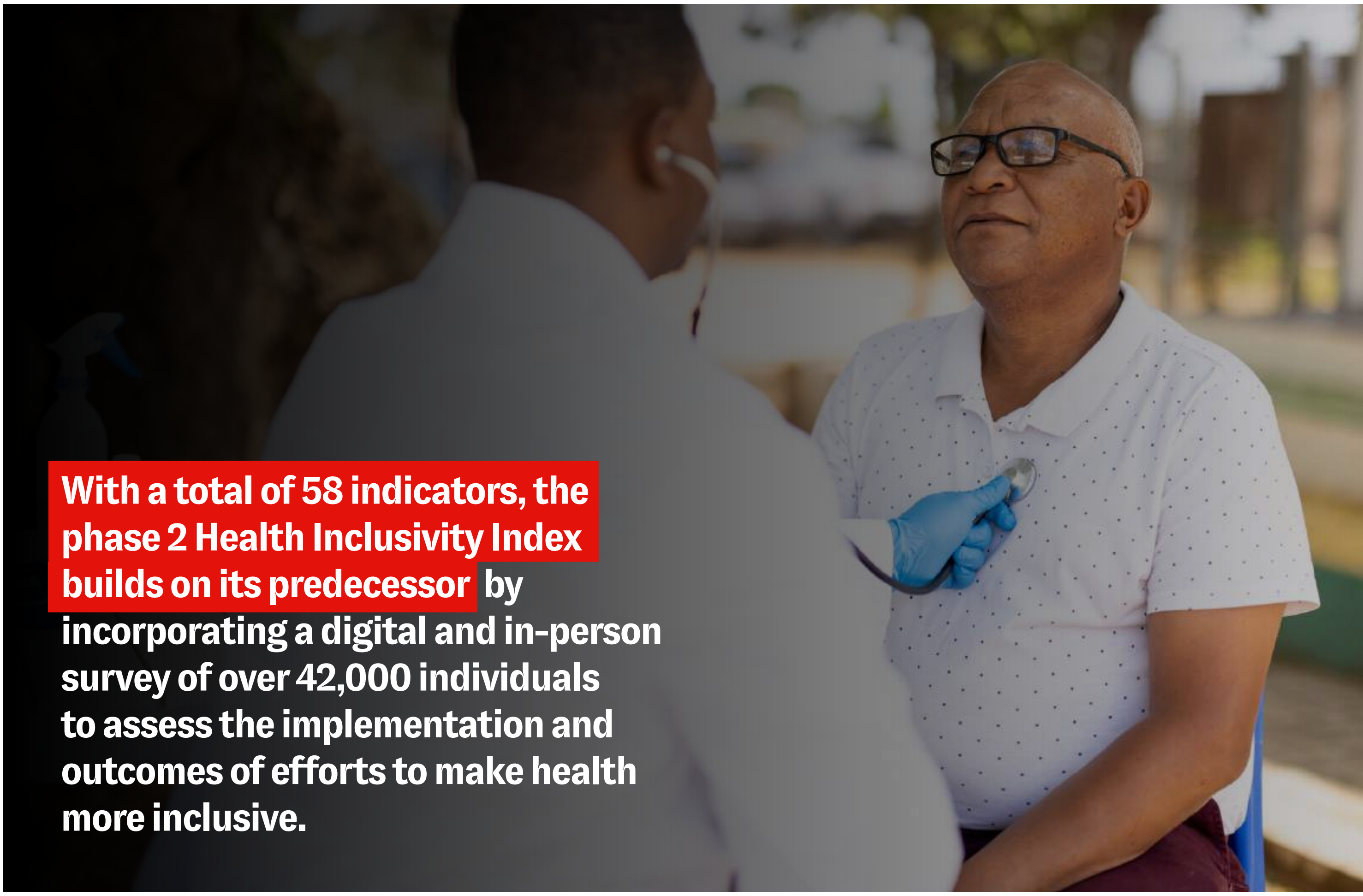
The phase 1 Index assessed the extent to which governments had enacted a policy framework and the essential structures to enable fair access to the conditions and systems supporting good health. In other words, it looked at the key "inputs" required to facilitate health inclusivity but placed less focus on the "outcomes" of these measures.

This assessment provided original and valuable insights regarding the efforts of governments around the world to lay the groundwork for health inclusivity; however, questions remained around the degree to which countries' policy environments are actually reducing exclusion for key populations. Answering such questions is particularly critical when striving to achieve health inclusivity. Without taking steps to ensure that the experiences of individuals and communities—especially those from vulnerable groups—are taken into account, we risk reinforcing structural barriers and failing to address the challenges of those most in need.

To address this gap, the phase 2 Index incorporates additional measures to assess implementation and outcomes of efforts to make health more inclusive. Economist Impact surveyed over 42,000 individuals living in 39 of the 40 countries included in the Index.[iii] The survey included questions on lifestyle, health and access to systems to generate novel data on inclusion—and exclusion—when it comes to health.

[iii] Survey data for Cuba was approximated using data from three other Latin American countries: Brazil, Colombia and Mexico.

The phase 1 Health Inclusivity Index leveraged 37 indicators organised across three domains to assess the policy framework and systematic structures to support health inclusivity.



With a total of 58 indicators, the phase 2 Health Inclusivity Index builds on its predecessor by incorporating a digital and in-person survey of over 42,000 individuals to assess the implementation and outcomes of efforts to make health more inclusive.

Figure 6: Health Inclusivity Index domains

Domain 1:

Health in Society evaluates whether inclusion is prioritised in health policy, a *Whole of Society*[IV] approach is applied to integrate health-related issues across government departments and policies and the translation of these policy priorities and approaches occurs in practice.

Policy indicators include: policies addressing food insecurity and healthy eating; the social determinants of health; and intersectoral cooperation.

Implementation indicators include: access to education, access to housing and food security.

Domain 2:

Inclusive Health Systems assesses health system infrastructure and workforce density, as well as the availability and accessibility of key healthcare services on the ground.

Policy indicators include: healthcare providers per 10,000 people; existence of an electronic health record system; and domestic government health expenditure.

Implementation indicators include: availability of essential healthcare services; access to affordable care; and discrimination in quality of care received.

Domain 3:

People and Community Empowerment explores government efforts to ensure health services are inclusive and empowering, as well as populations' access to and ability to use these measures in practice.

Policy indicators include: the existence of policies and programmes for improving healthcare translation capacity, person-centred care and engagement in health policy development.

Implementation indicators include: quality of engagement with healthcare, access to health information and social cohesion in the community.

[IV] Equivalent to the Health in All Policies approach, defined in the 2013 Helsinki Statement, which describes "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."

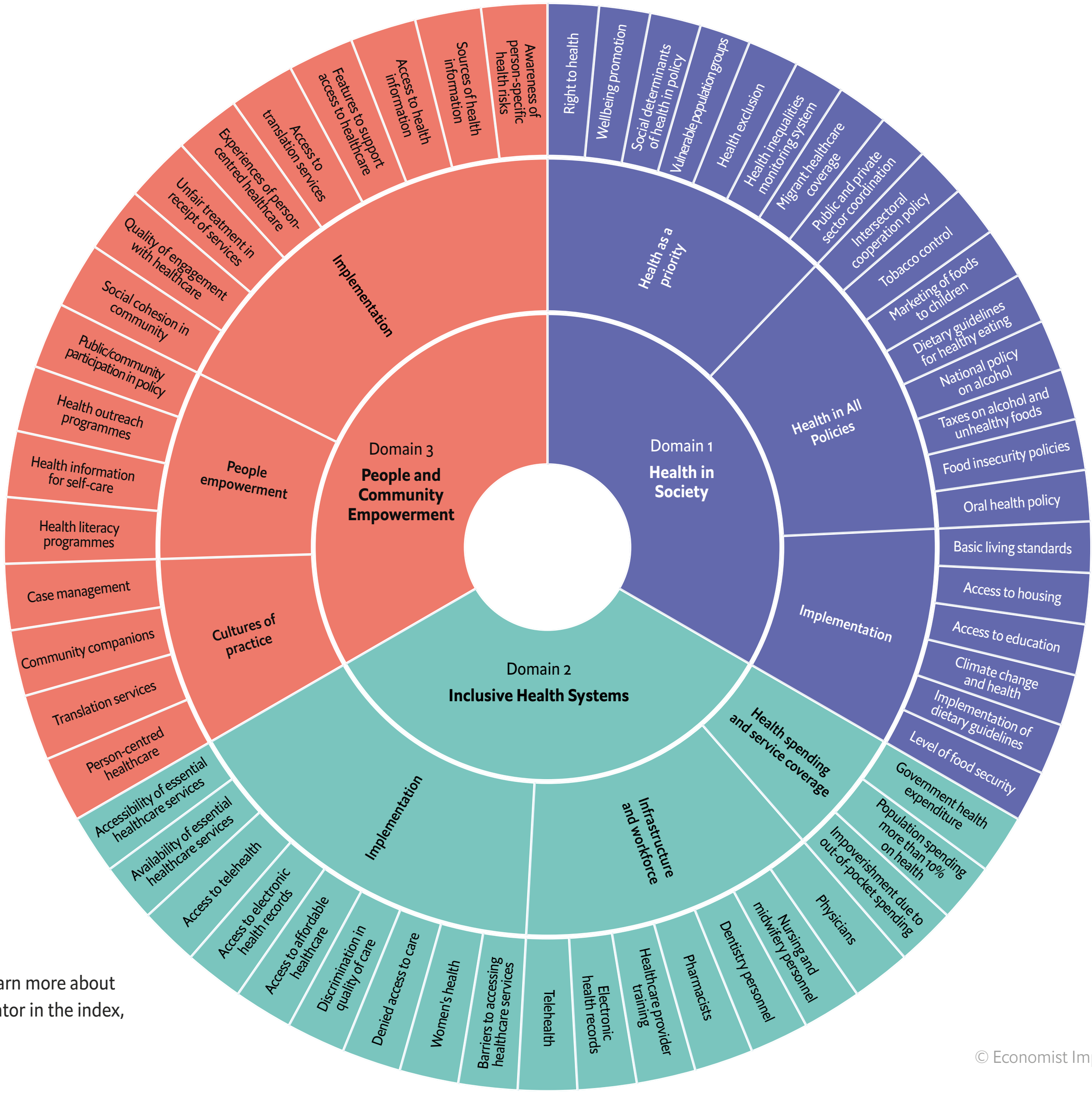
To ensure broad participation from all segments of the population, including those with limited agency and without access to the internet, the survey was fielded both digitally and in person.[V] With support from a global field team, in-person responses were gathered from over 2,500 individuals living in more rural or resource-limited areas in seven countries.[VI] We then undertook analysis to scale the digital survey data in the 32 countries where we did not conduct in-person surveys to be inclusive and reflective of the entire population in each country (see Appendix B). The resulting data were then incorporated into the Index as additional indicators capturing the translation of policies and programmes into action across the original three Index domains:

[V] As defined by UNESCO, the "digital divide" refers to the "gap between individuals, households, businesses and geographic areas at different socioeconomic levels with regard to both their opportunities to access information and communication technologies, and to their use of the internet for a wide variety of activities."

[VI] The seven countries include Germany, India, Kenya, Thailand, the UAE, the UK and the US. Efforts to conduct a similar in-person study in Brazil are underway.

Figure 7: The Health Inclusivity Index framework

The Health Inclusivity Index assesses policies and processes using 58 indicators, measured across three domains. Domain 1: Health in Society (22 indicators); Domain 2: Inclusive Health Systems (19 indicators); Domain 3: People and Community Empowerment (17 indicators). Domains were assigned the following weights: Domain 1 (30%); Domain 2 (35%); Domain 3 (35%)

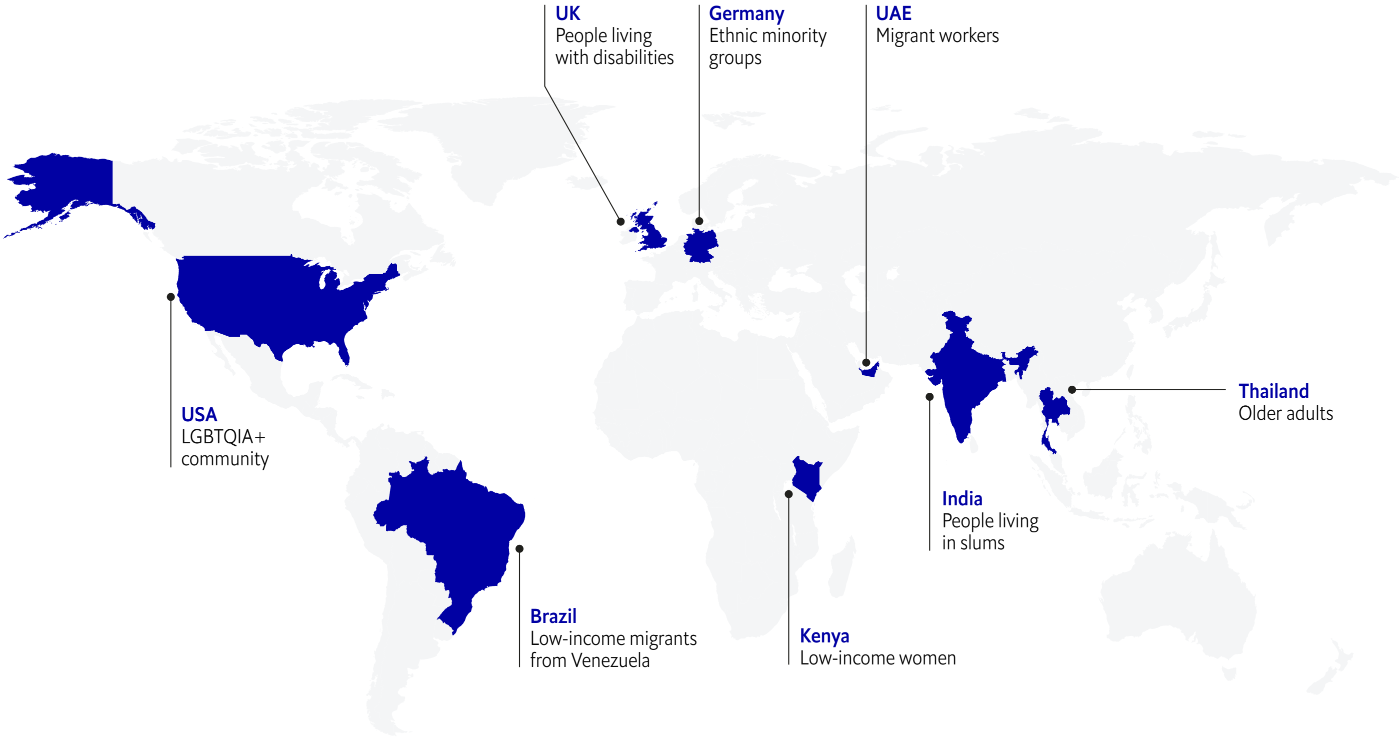


Note: to learn more about each indicator in the index, click here.

To gather additional insights into the unique challenges that more vulnerable groups face when interacting with systems and maintaining good health, as well as the availability of support systems to overcome barriers, we also conducted a series of focus group discussions. These discussions included between seven and ten participants from specific populations and community groups—including persons living with disabilities, minority ethnic persons and members of the LGBTQ+ community, among others (see Figure 8)—to add more context to our research and analysis. Finally, we conducted eight interviews with international civil-society organisations (see Appendix B) who support other vulnerable populations and marginalised groups that we were unable to engage directly during the research.[VII]

Figure 8: Focus group discussions

Populations of interest for focus group discussions in our eight deep-dive countries



[VII] For a more detailed explanation of the research methods, analysis approach and limitations please consult our detailed methodology available from https://impact.economist.com/projects/health-inclusivity-index

Figure 9: Overall Health Inclusivity Index scores
Index scores by country

Where we are today

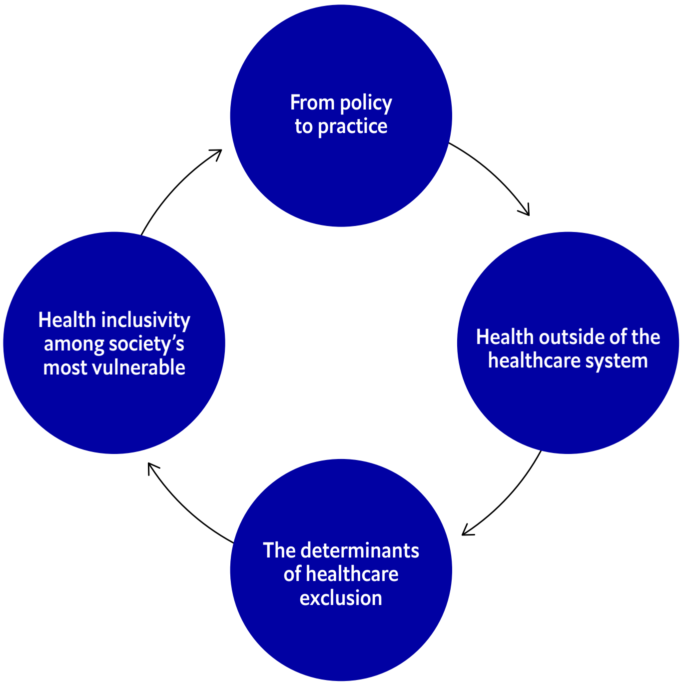
The phase 2 Health Inclusivity Index clearly demonstrates that a significant amount of work remains globally to build more inclusive health systems and societies. Just one country in the Index—Australia—receives an overall score greater than 80 (out of 100), and the average score across all countries is just 63. Countries have been most successful at integrating inclusion into national policy and adopting a "whole-of-society" approach through cross-governmental coordination; however, the low overall average score across countries highlights the difficulty of translating policies into action and the need for greater focus to ensure that systems and structures are inclusive and accessible to all.

Australia has the highest score on the Health Inclusivity Index, followed by Sweden and the UK. However, with all but one country scoring below 80, significant effort is needed to truly embed health inclusivity.

Globally, Europe is the most health-inclusive region, while Southeast Asia and the Eastern Mediterranean are the least.[VIII,IX] High-income countries tend to perform better overall than middle- or low-income countries. Despite these trends, low- and middle-income countries have areas of strength; for example, they are more effective at fostering inclusion through community-based service delivery.

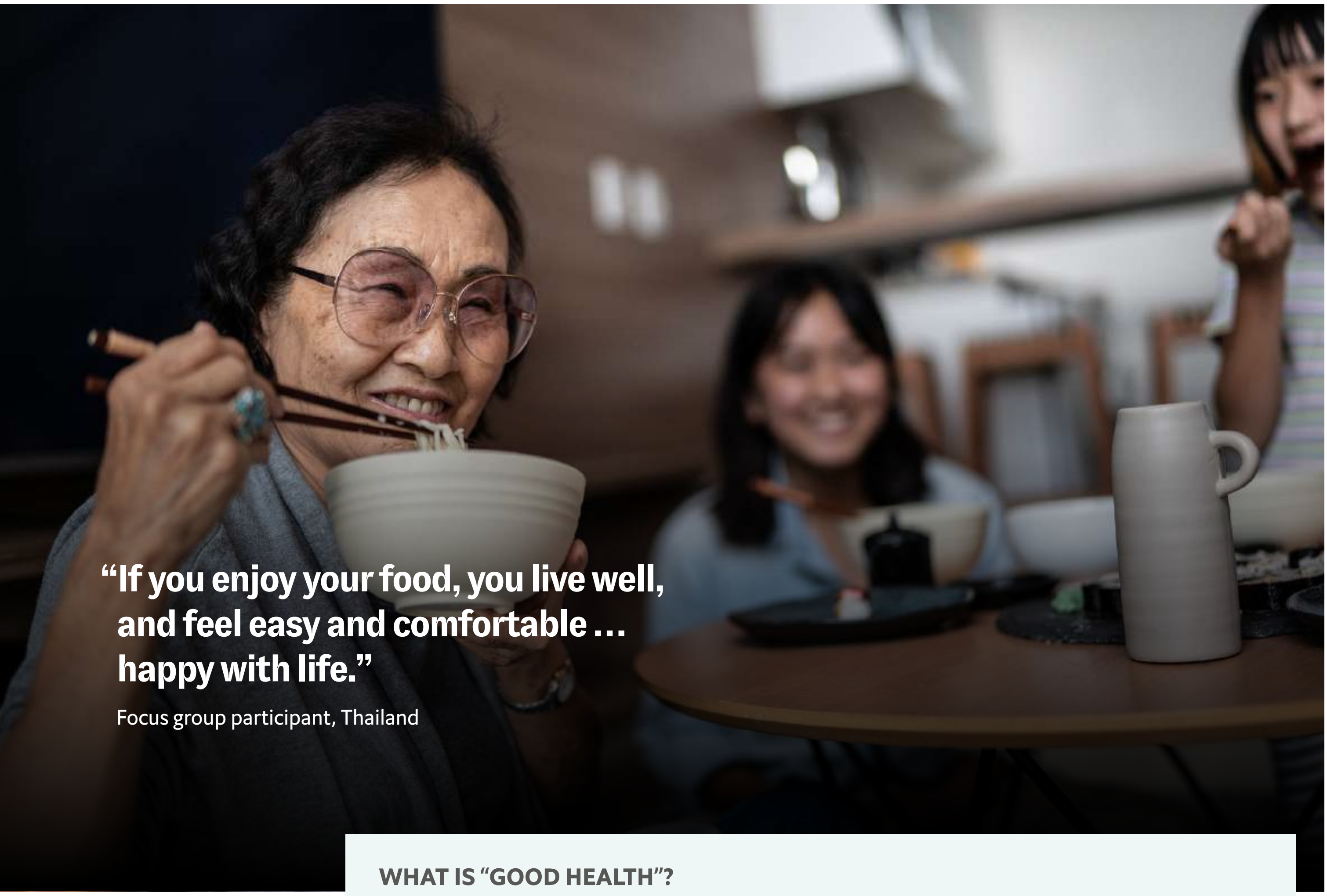
The following sections explore some of the factors that hinder or advance progress on health inclusivity. These findings are presented against four interrelated themes that emerged from our research and analysis (see Figure 10).

Figure 10: The four themes of the Health Inclusivity Index



[VIII] Index countries from Europe include Sweden, France, the UK, Israel, Germany, Switzerland, Slovenia, Italy, Turkey, Kazakhstan, Poland, Russia and Ukraine; Southeast Asia countries include Thailand, Indonesia, India and Bangladesh; Eastern Mediterranean countries include Egypt, Jordan and the UAE

[IX] Regions are defined using the World Health Organization classifications. See: https://www.who.int/countries



> **“If you enjoy your food, you live well, and feel easy and comfortable … happy with life.”**

Focus group participant, Thailand

WHAT IS “GOOD HEALTH”?

The Health Inclusivity Index assesses the accessibility of “good health”.[3,X] The interpretation of “good health” may differ from location to location and culture to culture. To better understand how people around the world are thinking about and defining what it means to be healthy, we engaged with over 50 individuals across eight countries and posed the question, “what does good health mean to you?” Three main concepts emerged from these discussions:

Good health…

….signifies the ability to enjoy life and engage in work without being restricted by health conditions or concerns;

…entails the ability to access healthcare systems when you need them;

…has evolved over time from a primary focus on physical health to encompass other dimensions, including mental and social wellbeing.

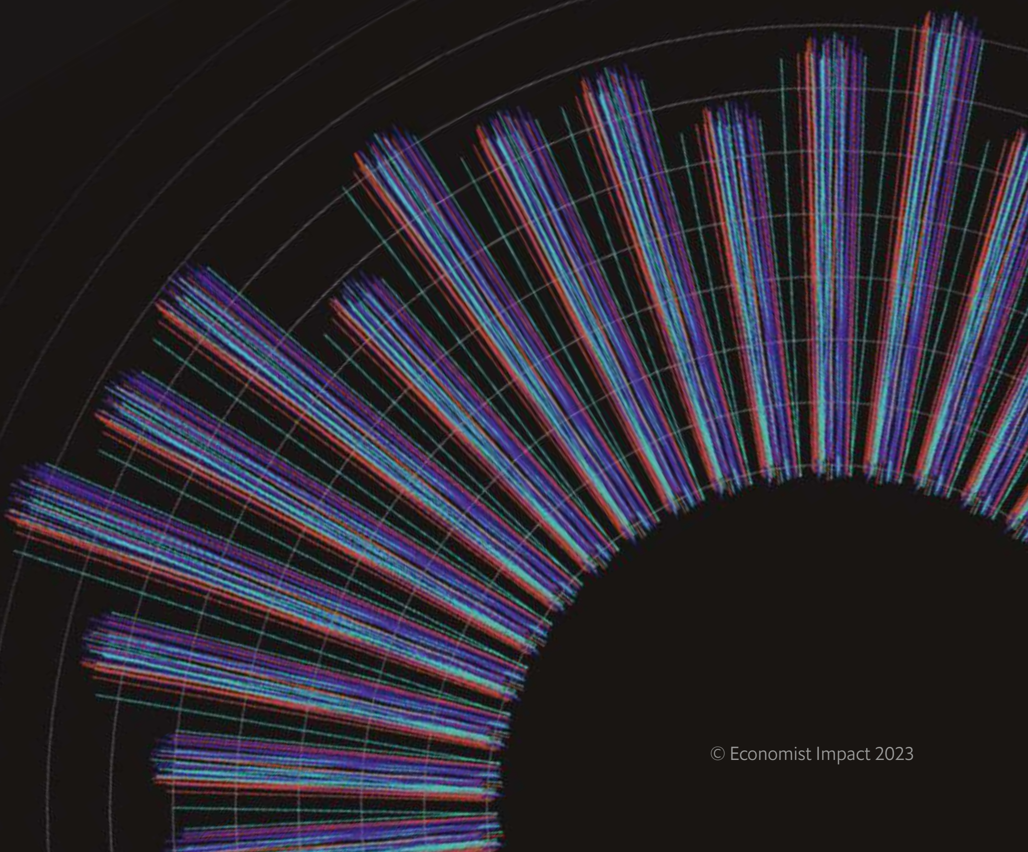
> **“I think it includes a level of functionality or functioning—with whatever helps you function, for lack of a better term, normally. Like, how people should just function in society. So, even if you have a chronic condition or a mental condition that requires medication, [good health means] having things that will help you process and perform. ”**

Focus group participant, US

[X] The WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

> “I would say that when people talk about health, usually the first thing that comes to mind is physical health. When they want to talk about mental or social [wellbeing], it has to be specified [as such]. But the importance of [both are], I would say, becoming significantly important.”

Focus group participant, Munich, Germany



From policy to practice

Our assessment of health inclusivity across 40 countries includes two main components: the degree to which a country has a broad legislative, policy and strategic framework for inclusive health, and the extent to which these frameworks are delivering meaningful outcomes for its population—as measured through our global digital and in-person survey of over 42,000 people. A country's total health inclusivity score consists of these two measures.

Disparities between policies and implementation

The Index reveals that significant gaps exist between the presence of policies to drive inclusive health and the experience of associated actions.[XI] The average score on policy-related indicators is 67, while it is 9 points lower on implementation-related indicators. These gaps have notable impacts on countries' overall health inclusivity scores: the majority of countries (34 out of 40) saw a decline in their score when population experiences were factored into the Index.

58% of countries have measures in place to increase access to translation services and provide health materials in other languages; however, just 32% of people in these countries report having access to such services in reality.

[XI] In this context, we define "health inclusivity policy" as the laws, regulations, plans, strategies and programmes that aim to achieve holistic and equitable health goals in a society.

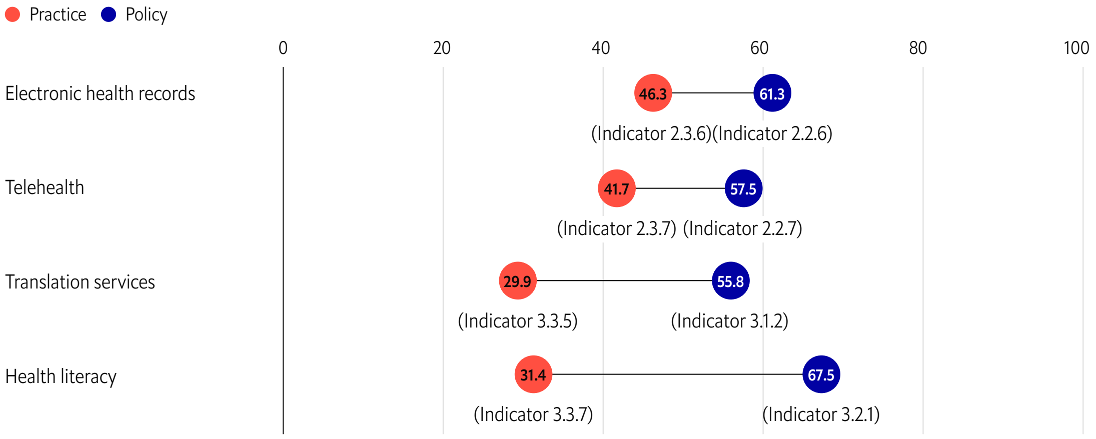
There is a disconnect between the policies in place on paper and the lived experiences of individuals and communities.

The Index sheds light on how policy-implementation gaps manifest on the ground (see Figure 11). Although three in four (78%) countries have a national policy or strategy on person-centred care, only one in two survey respondents agree that their personal preferences, including cultural preferences, are taken into account when they receive care. Additionally, although almost 90% of countries have national dietary guidelines for healthy eating, more than a third of people (37%) are not familiar with them.

These findings indicate that the health inclusivity policy environment in most countries is stronger than the implementation environment. Put simply, there is a disconnect between the policies in place on paper and the lived experiences of individuals and communities. Action to address this disconnect is crucial to ensure that policies are translating into their intended benefits for all members of society.

Figure 11: The gaps between policy and practice across indicators

Average scores (0-100) for policy and corresponding practice indicators

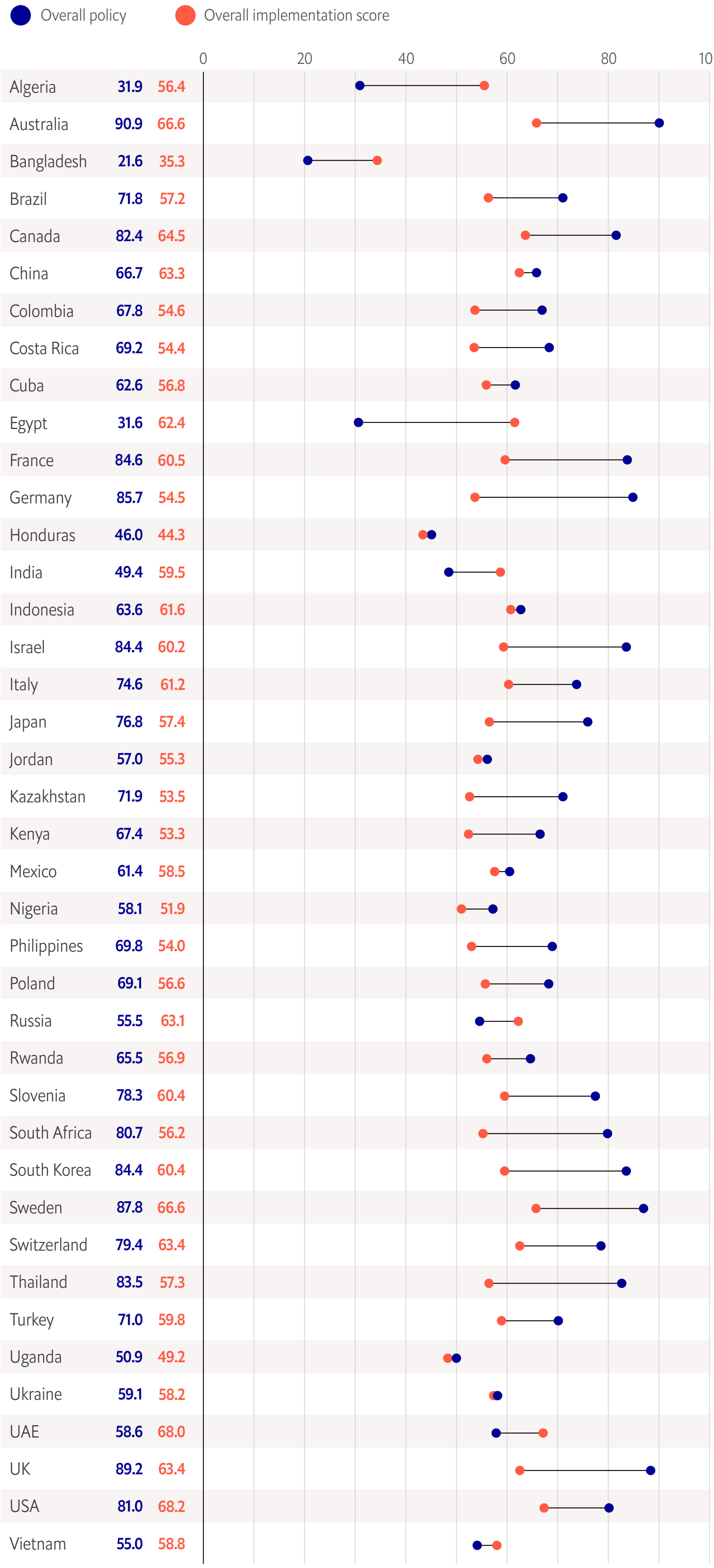


Electronic health records	Telehealth	Translation services	Health literacy
2.2.6 Electronic health records systems	2.2.7 Telehealth policy	3.1.2 Policy for translation services	3.2.1 Policies for health literacy programmes
2.3.6 Access to electronic health records	2.3.7 Access to telehealth	3.3.5 Access to translation services	3.3.7 Access to health information

For more information about these indicators, please see Appendix A.

Figure 12: Comparing policy to practice

Overall policy scores compared to overall implementation scores, by country



	Overall policy	Overall implementation score
Algeria	31.9	56.4
Australia	90.9	66.6
Bangladesh	21.6	35.3
Brazil	71.8	57.2
Canada	82.4	64.5
China	66.7	63.3
Colombia	67.8	54.6
Costa Rica	69.2	54.4
Cuba	62.6	56.8
Egypt	31.6	62.4
France	84.6	60.5
Germany	85.7	54.5
Honduras	46.0	44.3
India	49.4	59.5
Indonesia	63.6	61.6
Israel	84.4	60.2
Italy	74.6	61.2
Japan	76.8	57.4
Jordan	57.0	55.3
Kazakhstan	71.9	53.5
Kenya	67.4	53.3
Mexico	61.4	58.5
Nigeria	58.1	51.9
Philippines	69.8	54.0
Poland	69.1	56.6
Russia	55.5	63.1
Rwanda	65.5	56.9
Slovenia	78.3	60.4
South Africa	80.7	56.2
South Korea	84.4	60.4
Sweden	87.8	66.6
Switzerland	79.4	63.4
Thailand	83.5	57.3
Turkey	71.0	59.8
Uganda	50.9	49.2
Ukraine	59.1	58.2
UAE	58.6	68.0
UK	89.2	63.4
USA	81.0	68.2
Vietnam	55.0	58.8

The high-income gap between policy and action

The difficulties in implementing health policy are well-documented. Challenges include misalignment between priority policy objectives and resource level, as well as bureaucracy and lack of political will.[4,5,6] Furthermore, a country's level of development and economic context can shape implementation challenges.[6]

Interestingly, the Index reveals that high-income countries have the widest gaps between policy ecosystems, which aim to drive inclusion ambitiously, and the implementation of these policies. On average, there is a 18-point gap between indicators focused on policy compared with those focused on implementation in these countries. The reverse is true for low- and lower-middle-income countries, where the average score for implementation indicators is 3 points higher than scores for policy indicators.

Importantly, the gap in high-income countries should not be interpreted to mean that these countries have made less progress in implementing health inclusivity overall—high-income countries have higher overall average scores on implementation indicators than countries in other income groups. Instead, this gap shows that high-income countries have the furthest to go to ensure the experiences of individuals on the ground are aligned with the measures set out in policy.

The wide policy-to-practice gap in high-income countries underscores that strong health-inclusivity policy environments are, in themselves, insufficient to actually achieve health inclusivity.

High-income countries also tend to score higher on policy-related indicators. The aims, objectives and goals of systems to deliver inclusive health for individuals and communities are often more ambitious and more clearly delineated than they are in low- and middle-income countries. Yet, the wide policy-to-practice gap in high-income countries underscores that strong health inclusivity policy environments are, in themselves, insufficient to actually achieve health inclusivity.

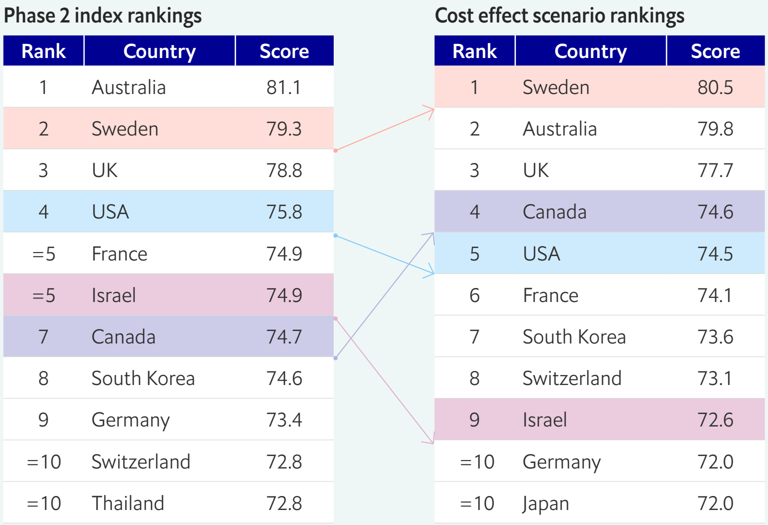
Although policy is a powerful step to making health a political and social priority, leaders in high-income countries must not get complacent. It is not enough to set the bar high. A higher bar necessitates even greater action to ensure that all members of society have access to the measures stipulated in policy frameworks. On the other hand, the "smaller" gap between policy and practice in low- and middle-income countries should not be perceived as a pretext for inaction. In many of these countries, there is a need to establish more robust policy environments to help facilitate progress across both policy and practice goals.

THE COST EFFECT—UNDERSTANDING THE ROLE THAT AFFORDABILITY PLAYS IN THE INDEX

One of the biggest questions that arose from the phase 2 Health Inclusivity Index is "how did the US move so far up the ranks when population experiences were added to the Index?" The US is one of the few high-income, Western economies that does not have universal health coverage and it has some of the worst health outcomes among these countries.[7] Health insurance in the country is tied to employment and even Americans with health insurance spend more out-of-pocket for their healthcare than in other countries, while Americans without insurance face risk of bankruptcy if they have a chronic condition or face a health emergency.[8] Our analysis shows that the existence and proximity of services in the US is not a challenge for most people. Affordability is the problem. The population experience indicators in the Index measure existence of, access to and affordability of services, and the US scores well on two of three of these issue areas.

To understand the impact that prioritising cost and affordability would have on the Index rankings, Economist Impact conducted a scenario analysis. We re-weighted the Index to put more emphasis on cost-related metrics, including access to affordable healthcare and basic living standards. Surprisingly, the results were quite similar to the existing scores and ranks (see Figure 13).

Figure 13: Cost-effect scenario rankings



Phase 2 index rankings

Rank	Country	Score
1	Australia	81.1
2	Sweden	79.3
3	UK	78.8
4	USA	75.8
=5	France	74.9
=5	Israel	74.9
7	Canada	74.7
8	South Korea	74.6
9	Germany	73.4
=10	Switzerland	72.8
=10	Thailand	72.8

Cost effect scenario rankings

Rank	Country	Score
1	Sweden	80.5
2	Australia	79.8
3	UK	77.7
4	Canada	74.6
5	USA	74.5
6	France	74.1
7	South Korea	73.6
8	Switzerland	73.1
9	Israel	72.6
=10	Germany	72.0
=10	Japan	72.0

Overall Index scores fell slightly. Canada sees the most improvement, rising from seventh to fourth, while Israel falls from fifth to ninth. The US falls one spot, to fifth, while Sweden overtakes Australia at the top.

This analysis helps us to understand that factors other than cost, including availability of health services and the policy environment, impact health inclusivity. Building health inclusivity involves addressing not only cost barriers, but also access to and availability of services, and the development and implementation of policies focused on inclusion.

Community empowerment: low- and lower-middle-income countries forge ahead

The People and Community Empowerment domain, which was found in phase 1 to be the strongest predictor of health inclusivity, measures the extent to which systems are in place to support individuals and communities to understand and take charge of their own health. Policy indicators include whether a country's policies and strategies support health literacy, person-centred care and translation services in healthcare. Implementation indicators assess the availability and accessibility of such measures in practice, and whether health systems and services are considerate of individuals' needs and preferences.

Although the majority of top-performers (nine of ten) in this domain are high-income nations, it is the presence of policies supporting people and community empowerment that drives this success. When implementation is taken into account, there is a 30-point gap between policy and practice performance for high-income countries in this domain.

73% of respondents in middle- and low-income countries have been given advice or information on how to manage their health at home, compared with 65% of respondents in high-income countries.

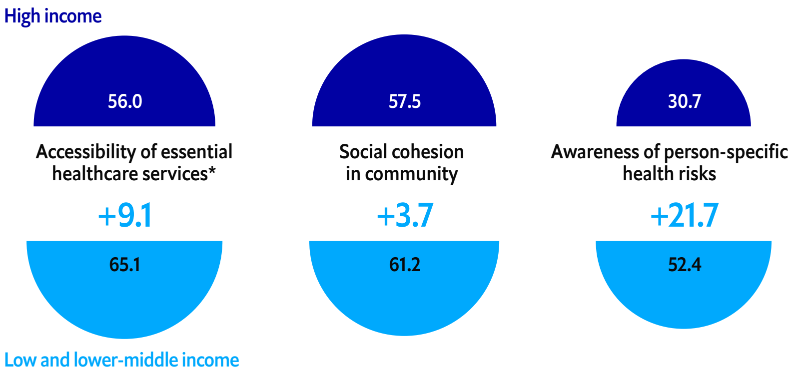
implementation of measures supporting individual and community empowerment is trailing policy advancements considerably.

And, while all countries have room for improvement in the People and Community Empowerment domain, several low- and middle-income countries outperform high-income countries, particularly on implementation indicators. Three in four respondents (73%) in low- and middle-income nations have been given advice or information on how to manage their health at home—information critical for helping individuals to understand their health and change unhealthy behaviours—compared with two in three respondents (65%) in high-income countries.

It is possible that these trends are the result of high-income countries' tendency to consider population health as a health-system responsibility. This approach risks overlooking the role of individual and community engagement in shaping overall health outcomes. On the other hand, the empowerment of individuals and communities may have emerged as a mechanism for filling access and resource gaps in low-and middle-income countries that have developing or less-mature health systems.

Figure 14: Where low- and lower-middle-income countries outperform high-income countries

Select average indicator scores (0-100)



Indicator	Description
Accessibility of essential healthcare services*	Can the general population access essential healthcare services in a timely manner?
Social cohesion in community	Level of social cohesion and trust at the community level
Awareness of person-specific health risks	To what extent do health professionals inform patients if they are at higher risk for certain health conditions, based on their background?

*where services are available

Moving forward, there is a clear rationale for high-income countries to address the implementation gaps around empowerment: evidence suggests individual agency can be as essential in reducing health inequalities as systemic and structural change.[9] Ensuring that top-down system responsibilities are balanced with bottom-up individual and community empowerment creates stronger and more sustainable systems and communities. Meanwhile, leaders in low- and middle-income countries should ensure that the push for universal health coverage does not come at the expense of the community dimension.

Not addressing the policy-practice gap hurts vulnerable populations most

Our findings highlight another critical observation: the gaps between policy and action can have a disproportionate impact on already vulnerable groups, including those from marginalised populations and individuals living with a chronic health condition. Of course, exceptions exist and individuals from these groups are not always more vulnerable. Likewise, vulnerability can exist outside of these groups. However, members of marginalised populations are often more vulnerable owing to a variety of social, economic and historical factors that can increase their chance of exclusion from various societal systems and place them at greater risk of exposure to certain health-related stressors.[10] Likewise, having a chronic condition is often interlinked with vulnerability due to increased reliance on healthcare systems and higher risk of interruption to education and work as a result of managing health conditions.[11]

Although 58% of countries have reasonable measures in place to increase access to translation services and health materials in other languages for people who need them, just 32% of people report actually having access to such services in these countries.

This study defines “marginalised populations” as: minority ethnic persons; persons with a disability; LGBTQIA+ persons; migrants; and refugees, asylum seekers or displaced persons. It refers to persons living with a chronic health condition and/or disease as “people with chronic health conditions”. Three in ten survey respondents globally self-identified as an individual from a marginalised population or person living with a chronic health condition.

Note: The marginalised populations considered in this study are based on the demographic questions included in our survey. We recognise that this list is not exhaustive and that other marginalised or minority groups may also face risks of exclusion within healthcare settings.

However, the consequence of this gap is often even greater for marginalised populations. For example, 21% of survey respondents who identified as migrants and 27% of refugees, asylum seekers or displaced persons indicated that language barriers have made it difficult to see a doctor or access other healthcare services in their community, compared to only 6% of the sample overall.

Given existing knowledge that marginalised populations and individuals living with a chronic health condition face greater risks of exclusion from healthcare[12], these findings might be unsurprising. However, observing the different levels of access across distinct population groups also reveals new insights on how policy-implementation gaps manifest in practice. Unless the extent of access gaps between the majority of the population and vulnerable groups are understood, stakeholders will struggle to design policies and programmes that ensure equal access and delivery of services to the entire population.

ADDRESSING THE CHALLENGES

Designing policy for implementation: Unfortunately, the passing of new policy is too frequently perceived as the end game, while implementation and follow-through are ignored.[13] Yet, the effective implementation of a policy is ultimately what determines its success, failure and, most importantly, benefits for a population. Therefore, it is essential that policies are developed with implementation as a central and guiding thought.[14] Policymakers should consider the main institutions, systems, actors and influences across the implementation ecosystem that could support or restrict policy implementation and effectiveness.[14,15] Designing policies that consider available resources is also key.

> **"If a country does not have a lot of financial resources, they must distribute those resources such that they serve the people who need them most."**
>
> Nikolaj Gilbert, President and CEO, PATH

Engagement of individuals and communities: Public engagement and representation in the development of national- and local-level health policy is critical to increasing the responsiveness of healthcare systems.[16] Local communities are best placed to understand local health needs. Engaging these stakeholders ensures that the communities being served adopt and trust systems and services. An effective point to engage the public is during implementation planning. However, our survey shows that over a quarter of people (26%) do not have the opportunity to discuss important issues with their community leaders. Policymakers should take action to eliminate barriers to participation and increase public engagement of vulnerable or less "visible" populations in policy development and implementation.

It all starts with data: Although many countries have stated a commitment to advancing equality in health, a lack of relevant data often inhibits their ability to develop informed policies. "If you feel that there are barriers, but do not have the data, then it's hard to spur investment in those barriers," says Nikolaj Gilbert, President and CEO of PATH. "If you have data ... it gives a platform for action." Collecting up-to-date, disaggregated data is key to developing evidence-based policies and reducing health inequities. Disaggregated data––including data on accessibility, affordability and quality of services—allow exploration of barriers along dimensions of gender, ethnicity, disability status, income group and age, and shows how people from different backgrounds experience health and wellbeing. Such data help to illuminate the unique challenges that various demographic groups face, helping policymakers and healthcare providers to understand their specific needs and tailor interventions to meet them. Policymakers should also ensure that the proposed approaches and interventions are rooted in the best available evidence.

Examples of action

Citizens' panels are representative, consultative bodies that local governments commonly use to identify the policy priorities of their community members.[17] Groups of citizens are randomly selected from a target population to participate in regular surveys, focus groups and workshops in order to garner a better understanding of peoples' lived experiences and inform policymaking. The panels are chosen to be representative of the community as a whole, as well as ensuring diversity along key demographic factors like age, gender, ethnicity, socioeconomic background and disability status. Citizens' panels are frequently used in the US and Europe and can cover a wide variety of local issues. The Citizens' Assembly in Ireland, for example, has held discussions regarding gender inequality in the workplace, challenges for ageing citizens and the societal impacts of addiction, with the aim of instituting policy reform.[18]

Health outside of the healthcare system

Health in Society is the highest-scoring domain, indicating significant progress in efforts to implement a whole-of-society approach to health; however, some subpopulations remain excluded from progress.

Efforts to improve health outcomes often focus on treating ill health through improving health-related infrastructure and access to healthcare services. However, healthcare is not the primary determinant of health. Instead, the conditions in which people are born, live, grow, work and age are.[19] The foundations of good health begin before birth and are reinforced at critical stages throughout life. Although estimates vary, it is widely recognised that access to healthcare only accounts for around 10% of a population's health, with the rest being shaped by socioeconomic factors.[20] Evidence suggests that a "whole of society" approach is required to make progress towards good health for all and reduce health inequities.[21]

The Index assesses the extent to which countries apply a whole-of-society approach to health through the Health in Society domain. This domain assesses whether countries are developing policies that prioritise health collaboratively across government; if the socioeconomic determinants of health are considered in health policy; and, importantly, whether populations—from an outcomes perspective—have inclusive access to basic necessities (eg, housing, education) that are social determinants of health.

A whole-of-society approach

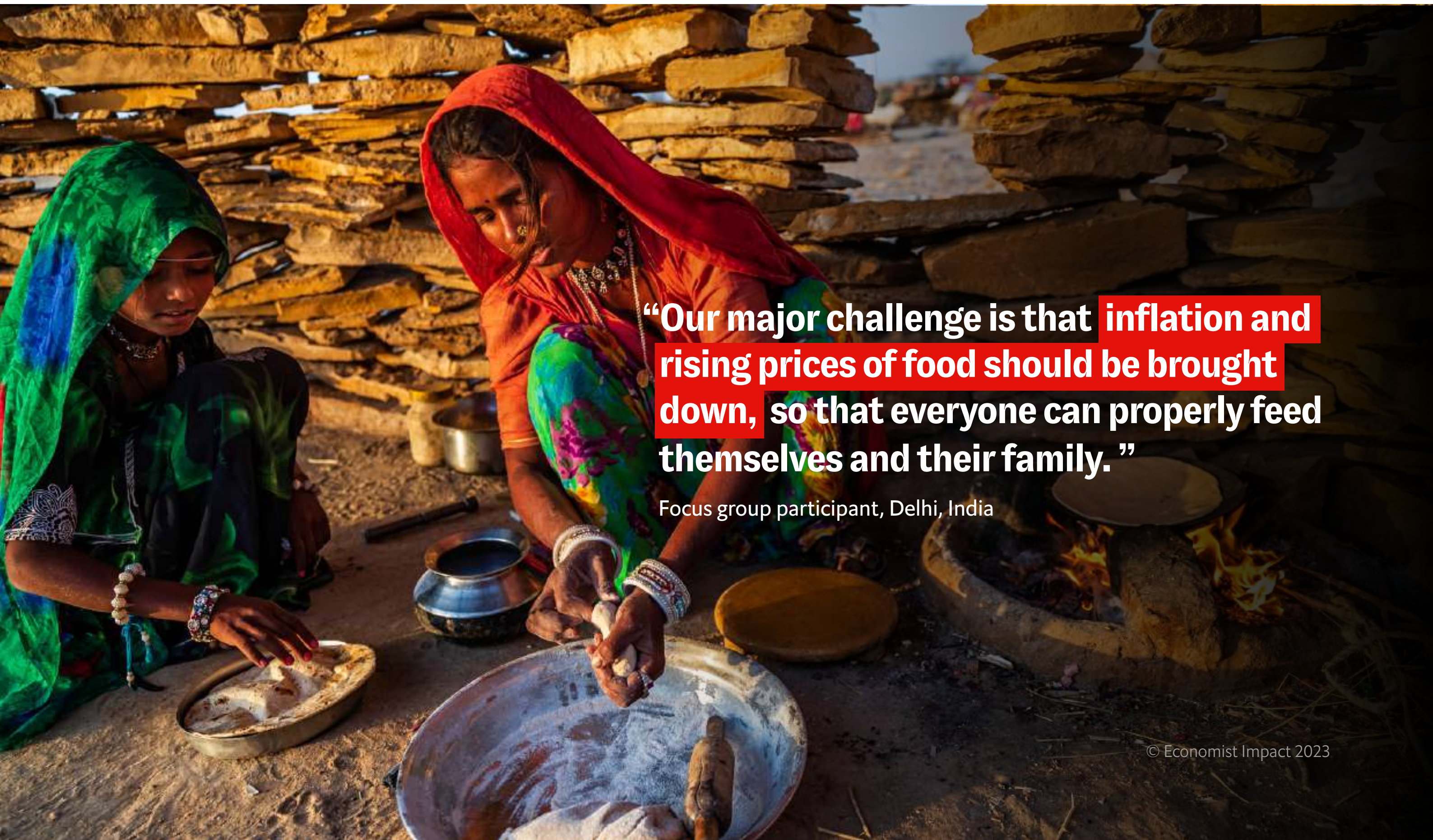
The Index findings suggest that a whole-of-society approach to health is relatively easy to design and implement: across the Index countries, the Health in Society domain has the highest average score (68), compared with 60 and 62, respectively, for the other two domains. However, gaps remain—countries fall short when it comes to engaging specific governmental departments and stakeholders on holistic health. More than four in ten countries (43%) do not have an operational oral health policy or strategy and 38% do not have policies in place on the marketing of foods to children. Although it is clear that countries are striving to establish health as a priority for all stakeholders, opportunities remain to strengthen mechanisms to systematically integrate health inclusivity.

“The outside of my house is knee-deep in dirty, stagnant water, especially when it rains. How can we go to get medicines in such a condition? ”

Focus group participant, Delhi, India

The socioeconomic barriers to inclusive health

Socioeconomic barriers and economic stressors, such as the global cost of living crisis—estimated to have pushed an additional 71mn people around the world into poverty in March-July 2022—have the potential to radically alter access to basic standards of living globally and drive health exclusion.[22] These stressors can reduce access to healthcare services and limit people’s agency to manage their health within the healthcare sector and in wider society.[23] Three in four countries in the Index (75%) include policies that address the social determinants of health, but socioeconomic barriers prevail within populations.



“Our major challenge is that inflation and rising prices of food should be brought down, so that everyone can properly feed themselves and their family. ”

Focus group participant, Delhi, India

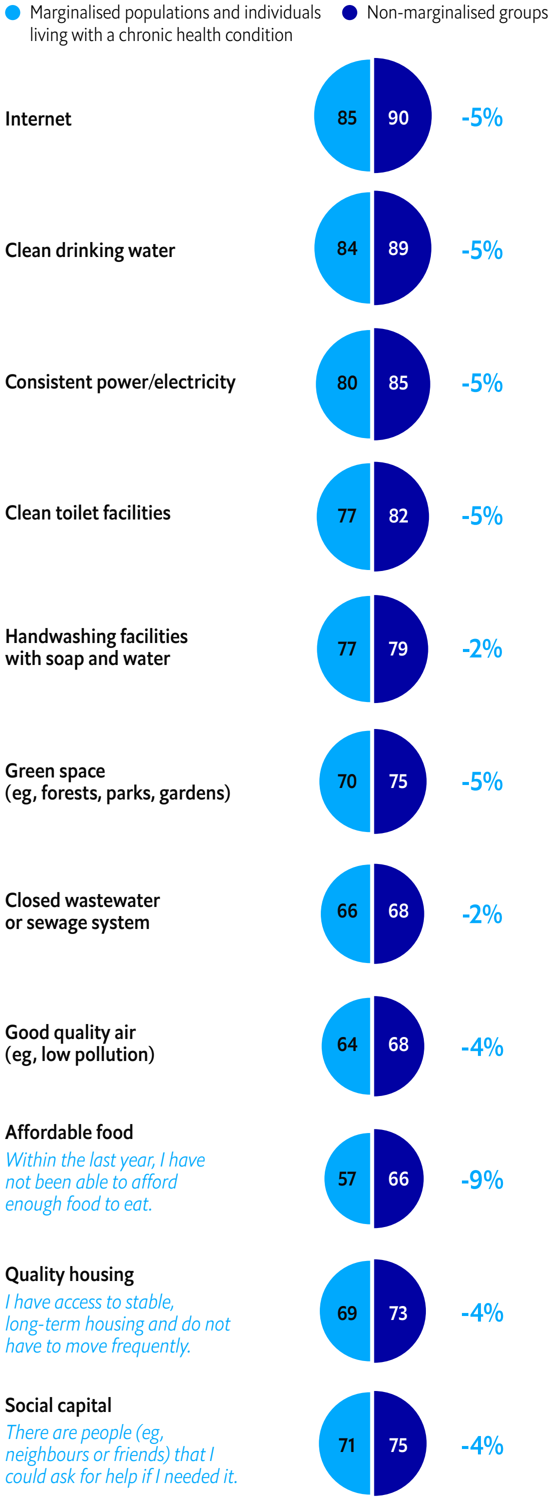
Our findings highlight that marginalised populations, individuals living with chronic health conditions and those with a lower level of education are more likely to experience these socioeconomic barriers. Fewer than six-in-ten respondents identifying as a member of a marginalised population or as an individual living with a chronic health condition (58%) agree that they have access to affordable, safe housing that does not harm their health. And three in ten (31%) do not have access to long-term and stable housing. “These two issues are very much linked,” says Nabeeha Kazi Hutchins, President and CEO of PAI. “When there is housing insecurity we also see significant insecurity in health and growing health inequities. In all cases, whether it be health, housing or education, those who are disproportionately affected are women and girls."

Alongside housing, education is a key barrier to health inclusion and plays a central role in reducing health inequities. Even in high-income countries, adults that have significantly lower educational attainment are more likely to suffer from poor health and engage in poor health behaviours (such as smoking, alcohol abuse and poor dietary choice) when compared with other population groups.[24,25]

Globally, nearly half of parents (47%) noted at least one barrier made it difficult for their child to attend school. And a parent’s education level can also be a barrier to their children’s access: 58% of parents with less than a secondary school education said that their child has faced a barrier to accessing education, compared with 45% of parents with a secondary education or technical degree. Ms Hutchins notes, "Education must be guaranteed for all young people and their families—this includes education and information on sexual and reproductive health and rights. When women and youth have information about their health, bodies and rights, gender-based violence, child marriage and teen pregnancy go down and gender equality, health equity and economic prosperity are improved.”

Figure 15: Social determinants of health: access to basic living standards, housing, affordable food and social capital, among marginalised populations and individuals living with a chronic health condition, as compared to non-marginalised groups

Percentage of survey respondents who have access to the following (%)



These trends are even more pronounced among marginalised populations and individuals living with a chronic health condition. Our survey found that 67% of individuals from these groups have experienced one or more barriers to their children accessing education, compared with just 38% of respondents from non-marginalised groups. Parents and guardians from a marginalised population or among those living with a chronic health condition are specifically more likely to experience cost-related barriers (such as tuition fees, exam fees and the cost of uniforms) that make it difficult for their child to attend school: 29% of respondents from these groups indicated that cost is a key barrier to their child's education, which presents a tangible opportunity to address non-healthcare barriers for targeted segments of the population.

Figure 16: The role of maternal health on early childhood development and long-term health outcomes

Pre-conception

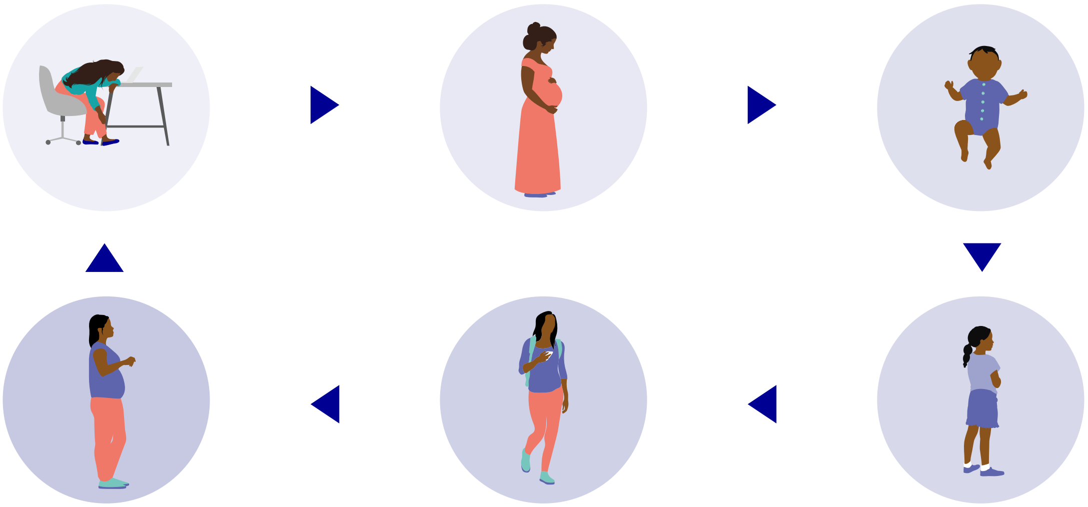
Social factors and stress can adversely influence a woman's ability to make healthy lifestyle choices, which can lead to poorer pregnancy-related and subsequent child development.[26]

Pre-birth

Insufficient prenatal care is associated with poor health outcomes for both mother and foetus, including preterm delivery, preeclampsia, and stillbirth.[27]

Infant

Infants born to mothers lacking access to prenatal care have a higher risk of being born with a low birthweight. Low birthweight is associated with lower immunity and chronic health conditions. [28]



Young adult to pre-conception

The long-term consequences of poor maternal health create a loop of intergenerational disadvantage. Rising inequities among the current generation can influence health-seeking behaviours and lifestyle choices that indirectly impact health outcomes for the next generation.

Young adult

The compounding impact of the prior stages of child development can lead to poorer health and social outcomes as the child transitions into adulthood, including a higher risk of chronic health conditions such as diabetes and high blood pressure, poorer educational attainment, and, subsequently, career prospects, all of which increase inequalities.[30,31]

Child

Such developmental complications can lead to children having problems in speech and language, vision, motor tasks, and attention, which can all impact school performance and attendance.[29]

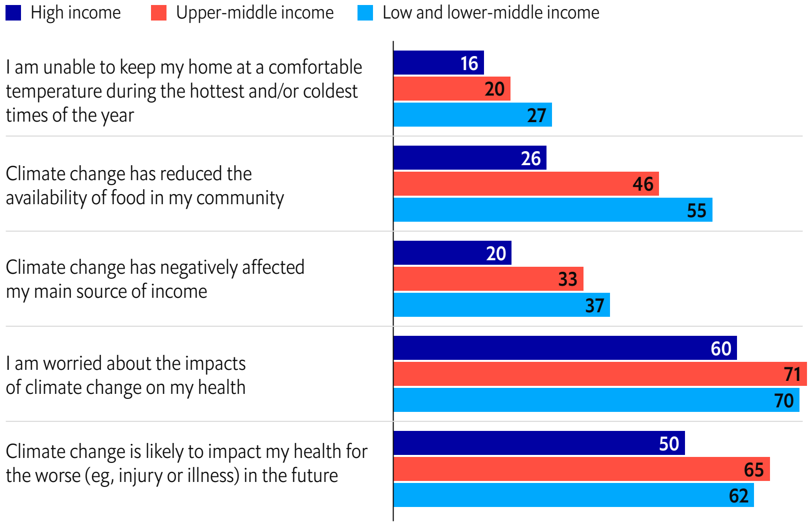
In alignment with global trends, the Health Inclusivity Index reiterates the urgent need for action on the intersection between climate and health, owing to the disproportionate impact of climate change on the health of populations in low- and lower-middle-income countries and of lower socioeconomic status.

Climate and health

Climate change is described by the World Health Organization (WHO) as the most significant health threat to humanity.[32] Its impact has become increasingly evident through extreme weather events from flash floods in Libya to wildfires in Southern Europe, Canada and Hawaii. Climate change influences social and environmental determinants of health, including access to clean air, safe drinking water, adequate food and secure shelter. It is projected that between 2030 and 2050, climate change will lead to approximately 250,000 additional deaths annually from malnutrition, malaria, diarrhoea and heat stress.[32] Younger generations are particularly worried about the impact of climate change: three-quarters of 16-25-year-olds report feeling frightened about their future and worry that governments are not doing enough to address the climate threat.[33] A study in Australia with over 5,000 adults indicated significantly higher rates of eco-anxiety[XII] among 18 to 24 year olds than older respondents, exacerbating an already increasing incidence of mental health issues across younger populations.[34,35]

Figure 17: Climate impacts by country income group

Percentage of the population that agrees with the following statements on climate change (%)



Higher-income countries tend to have more resources and networks to support adaptation to changing climate, and more resilient infrastructure (such as water systems and housing) to cope with erratic weather events and disasters.[36] The Health Inclusivity Index reflects this trend: high-income countries score an average of 67 on our indicator assessing the impact of climate on health, compared with an average of 53 in low- and middle-income countries. Over two-thirds of respondents in low-income countries (69%) agreed that climate change has strongly impacted food availability, while only one-quarter (26%) in high-income countries felt similarly (see Figure 17).

The impact of climate on health is likely to exacerbate enduring inequitable health outcomes across income groups, as people from lower-income countries and people in high- and middle-income countries with lower incomes often reside in substandard housing. The quality of this housing makes them more vulnerable to heat, floods, storms and disease. Limited access to healthcare exacerbates this existing vulnerability.

[XII] Eco-anxiety refers to distress related to the impact of climate change

Features of an inclusive system: connecting on- and off-line

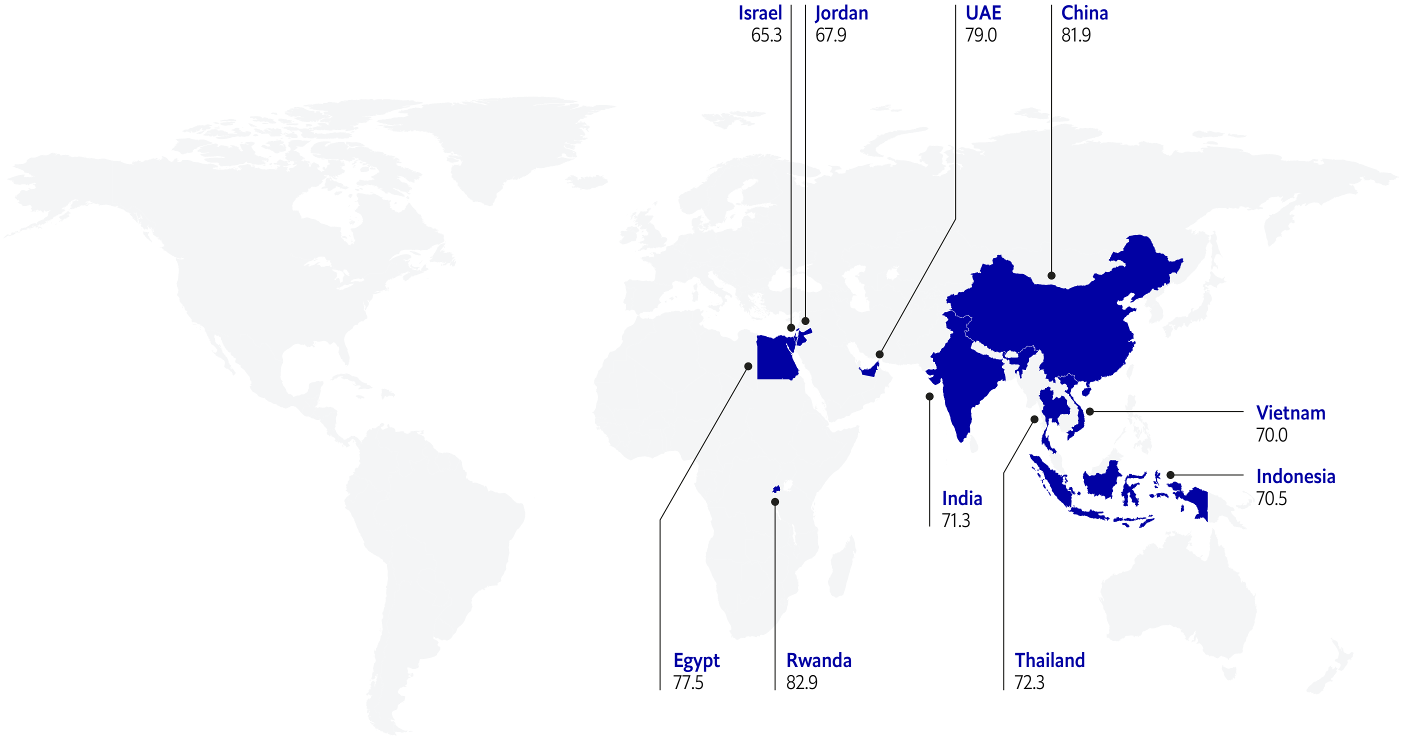
Digital transformation and the implementation of information and communication technology (ICT) in service delivery is one of the most prominent characteristics of inclusive healthcare systems across the globe. The widespread diffusion of the internet has enabled better access to health information and resources.[37] Our survey found that 72% of people with consistent access to the internet report having reliable and trustworthy information about a variety of health topics, compared with just 59% of those lacking internet access. However, the digitisation of health comes with challenges, especially for those with low levels of digital literacy and limited access to the internet, such as older persons.

Relationships are critical for physical and mental health and psychosocial wellbeing, whereas social isolation is deemed to be detrimental to health.[38,39] Despite respondents in high-income countries having greater access to basic living standards, this trend does not extend to our assessment of social cohesion. Rwanda, a low-income country, obtains the highest score for social cohesion and only two high-income countries—the UAE and Israel—score in the top ten (see Figure 18). Countries have the opportunity to leverage community-based mechanisms, such as community champions, to establish support networks across communities to drive good health and build social cohesion.

> **“I will say, besides being digitally literate, it's actually [a challenge] just being connected. I can search online as much as I like but it's seriously so hard. From the emails I've gotten or from the adverts I've gotten [about health] through an internet search, it's hard to figure out what to do. Like, where am I supposed to find this information? How am I supposed to know?”**
>
> Focus group participant, Munich, Germany

Figure 18: Top performers on social cohesion

Top 10 scoring countries on indicator 3.3.1) Social cohesion in community



> "When community members have a real voice in the decision making processes for their community about how to be prepared for climate change impacts, that process itself can strengthen the community. Neighbour to neighbour connections make communities more resilient. We've seen for example that during heat waves, the neighbourhoods that have fared the best and had the least mortality are those where neighbours check up on each other to make sure the most vulnerable residents, like the elders, are okay, or are getting to care if they need it. It is vitally important to involve community residents, if you want to develop climate resilience and response plans that actually work."

Dr Jeni Miller,
Executive Director,
The Global Climate
and Health Alliance

ADDRESSING THE CHALLENGES

Encouraging multisectoral collaboration: Health is deeply intertwined with various aspects of society, including education, housing and transportation. Therefore, health policy is not solely the responsibility of health ministries. Taking a whole-of-society approach to health requires that policymakers and other stakeholders from multiple sectors (housing and education, for example) work together to develop holistic, comprehensive policy frameworks that can positively impact population health.

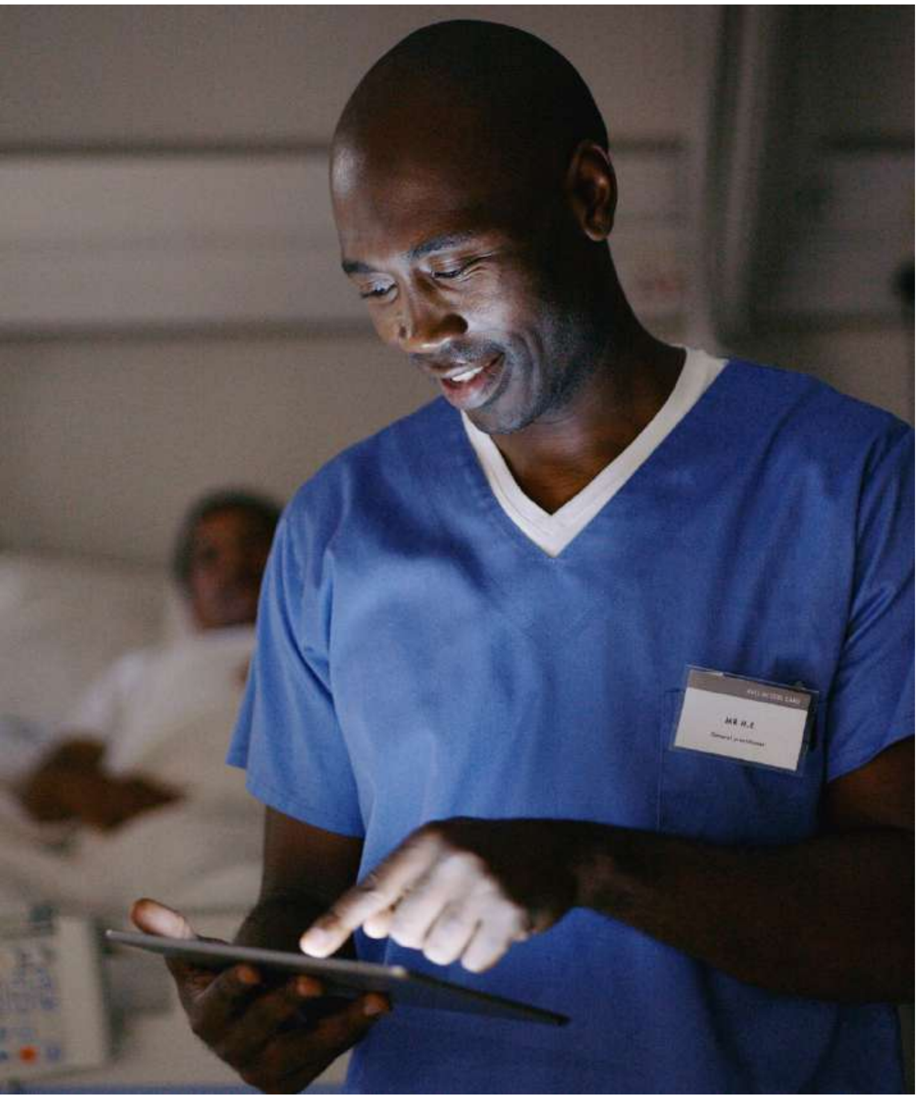
Anticipating the impacts of climate change: Although climate change is an established, global concern and threat to human health, more research is needed to better understand how best to cope with its effects. "Health systems—both healthcare and broader public health systems—need to build their capacity to anticipate, respond to and make good decisions about the impacts of climate change," says Jeni Miller, Executive Director of The Global Climate and Health Alliance. As the threat of climate change grows, countries must develop strategies for adaptation to support both healthcare systems and wider society. These strategies are especially important in areas that are particularly vulnerable to the impacts of extreme weather.

Leveraging community-based mechanisms: Community and support networks are a valuable resource for improving health outcomes. Numerous studies have established a link between social support and improved mental and physical health, leading to a better quality of life.[40,41,42] And, the benefits do not stop there: community networks can also be an important tool for policymakers. Mechanisms to involve community members in the policymaking process encourage accountability and ensure that policies are better aligned to population needs.[43] Yet, only 53% of Index countries have evidence of specific forums for community participation. Fostering collaboration with specific communities allows governments to create healthier environments, reduce health inequities and enhance the overall wellbeing of their populations.

Examples in practice

Chamas, utilised in East Africa and especially in Kenya, stand out as a best practice example of community-based mechanisms that can improve health and wellbeing. Chamas are informal co-operative societies that utilise microfinancing methods to gather and invest savings from a small group of individuals. These groups aim to reduce poverty by helping individuals to pay housing costs and school tuition fees. Such collectives are also often targeted to specific groups, such as pregnant or postpartum women, allowing them to address inequalities while promoting positive maternal and child health behaviours through education and peer support.[44] Thus, chamas leverage community support to address the social determinants of health and provide assistance to community members in need.

The determinants of healthcare exclusion



The UN Sustainable Development Goals (SDGs) recognise the importance of expanding affordable access to quality health and care services, as well as the critical role that health plays in driving growth and development. SDG target 3.8 aims to achieve universal health coverage—including access to quality essential healthcare services and affordable essential medicines and vaccines—by 2030. However, many people around the world still do not have access to affordable primary healthcare and are unable to fulfil their basic health needs.[45] In addition, resources are limited: the WHO projects a shortfall of 10mn health workers by 2030, mostly in low- and lower-middle-income countries.[46] Building inclusion into healthcare service design and delivery is vital to reducing preventable illness and ensuring that all people are able to live longer in good health.

World Bank and WHO research estimates that countries need to increase spending on primary healthcare by at least 1% of GDP in order to close current coverage gaps and meet the SDG health targets.[47] Despite global leaders' commitment to the SDGs, the Index reveals that access to a range of essential health-related services is inconsistent, and that, for many, cost and other barriers are denying people the critical healthcare services that they need.[48]

> **If the availability of primary care doctors in low- and lower-middle-income countries in our sample was the same as in high-income countries, approximately 262mn more people would have a primary care doctor available in their community.**

Availability, timeliness and location of care

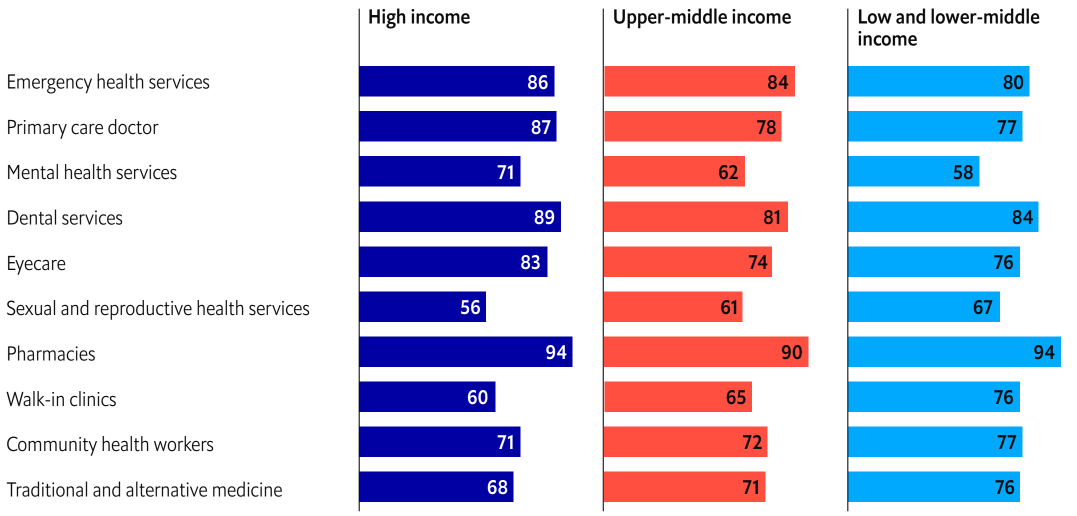
Location and income are strong predictors of availability and timeliness of healthcare services. WHO Global Health Observatory data show that high-income countries generally have a higher density of key healthcare workers—doctors, nurses and dentistry personnel—per 10,000 people than low- and middle-income countries.[49] Our survey shows similar trends: higher numbers of respondents in high-income countries than in low- and lower-middle-income countries report that essential providers and services are available in their local communities (see Figure 19). Although differences in availability of about 10 percentage points might not sound substantial, if the availability of primary care doctors in low- and lower-middle-income countries in our sample was the same as in high-income countries, approximately 262mn more people would have a primary care doctor available in their community or 10% more people in these countries.

> **“You have been prescribed medicine, [but] you have no money … to go to the chemist to buy medicine. You will just have to bear with the situation.”**
>
> Focus group participant, Nairobi, Kenya

Interestingly, when essential services are available in low- and lower-middle-income countries, they are accessible more rapidly than in high-income countries. Four in five (79%) respondents in low- and lower-middle-income countries said that they could access a primary care doctor within 24 hours, while just over half of people in high-income countries (55%) indicated the same. However, rapid access does not always equate to accessibility, and major barriers, including the cost and quality of healthcare, remain a concern.

Figure 19: Availability of essential healthcare service providers by country income group

Percentage of the population reporting that the following healthcare services are available in their community (%)



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Community services are a central component of inclusive health and care systems. Community health workers and other health professionals, like community pharmacists, play an important role in facilitating greater access to healthcare services and information for good health.[50] Community health workers also have greater potential to reach groups at higher risk of exclusion from conventional health services, including people with limited literacy and people living in more rural regions.[51]

> **"There are health volunteers who are helpers. Each health volunteer looks after 15 households. They make their records up to date and monitor the health issues found. They are the front line in public health issues, [such as] when there is a chronic ailment and the patient can't go to get their pills as scheduled. "**
>
> Focus group participant, Ban Lao-Kwien, Thailand

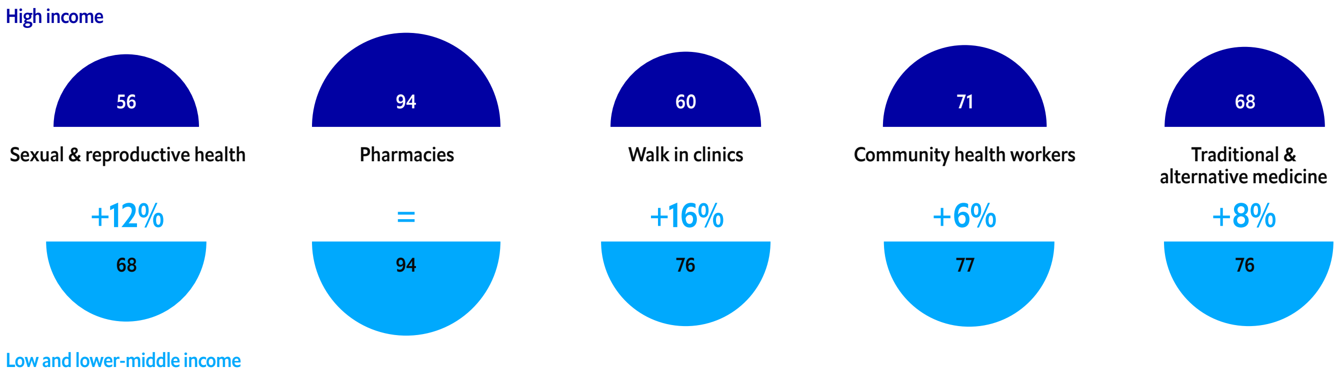
Nikolaj Gilbert from PATH, highlights, "Community health workers play a large role. They meet people where they are at, checking in with them in their homes. This means they receive treatment that works for them and that health workers can identify factors that may be contributing to the spread of disease and address those issues too."

Given that these professionals and services are based in the communities that they serve, these measures can be an important tool for breaking down cultural barriers and increasing the relevance of services and advice.[50] Dr A. Kayum Ahmed, Special Advisor on the Right to Health for Human Rights Watch, tells us that centring community-based knowledge systems is essential: "Indigenous communities often understand health in ways that connect the body to the land, compared to Euro-American conceptions of health, which tend to centre a biomedical approach."

We found that low- and lower-middle-income countries tend to place more emphasis on community-based service delivery. Respondents in these countries were 9 percentage points more likely to indicate that the five core community-level services are available in their local area, when compared to their counterparts in high-income countries (see Figure 20).

Figure 20: Availability of community-based health services by country income group

Availability of five community health services by country income group (%)



These findings help to shine a light on the extent to which community-based services are prioritised to further increase health inclusivity across regions and income groups. Considering the link between community-based services and access to and use of basic services, especially among vulnerable populations, higher-income countries could draw valuable lessons from this approach and embrace more community-centric healthcare and service delivery.[52]

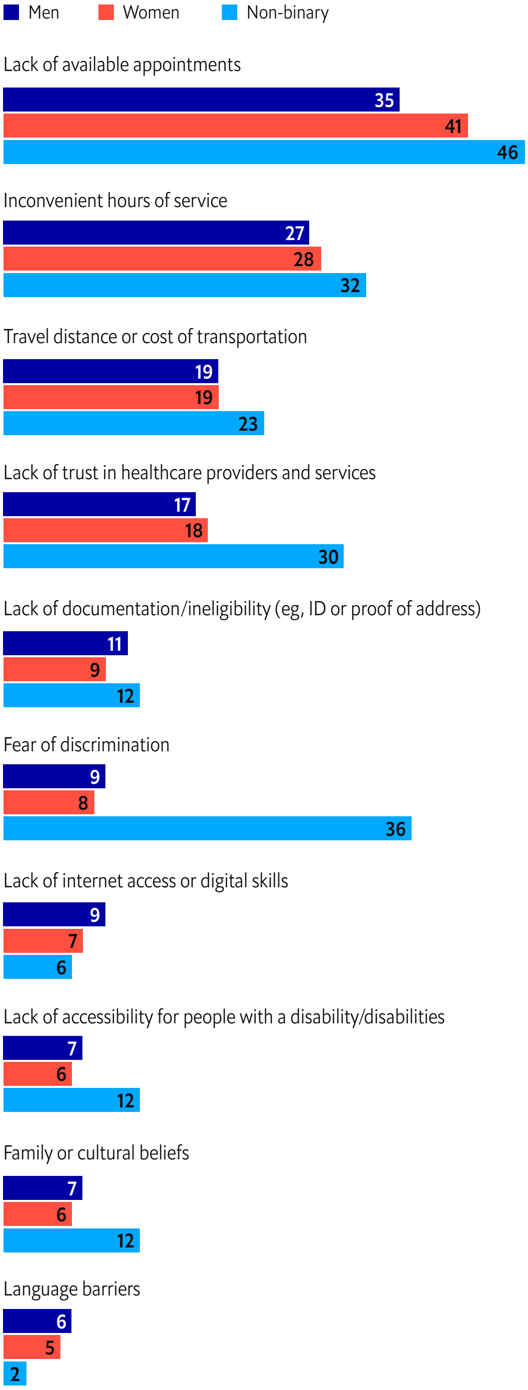
However, such reforms are not enough by themselves. “Community health workers are a good investment for governments looking to increase the connectivity between communities and healthcare,” says Andrew Clarke, Senior Health Advisor with Save the Children UK. "However, it is critical that this investment also be accompanied by action to address the structural inequalities perpetuating inequities and poor outcomes in the first place.”

Gaps in access to essential healthcare services

Globally, the gender health gap prevails. Women tend to have less access to healthcare and poorer outcomes, after treatment and across a spectrum of health issues, than men.[53] Although women generally live longer, they also spend more of their years living in disability and/or with a poorer quality of life.[54] These findings are validated in our research: survey results indicate that cost and lack of available appointments are the primary barriers to accessing healthcare—and female respondents are more likely to experience these barriers than males (see Figure 21).

Figure 21: Barriers to healthcare access (outside of healthcare costs) by gender

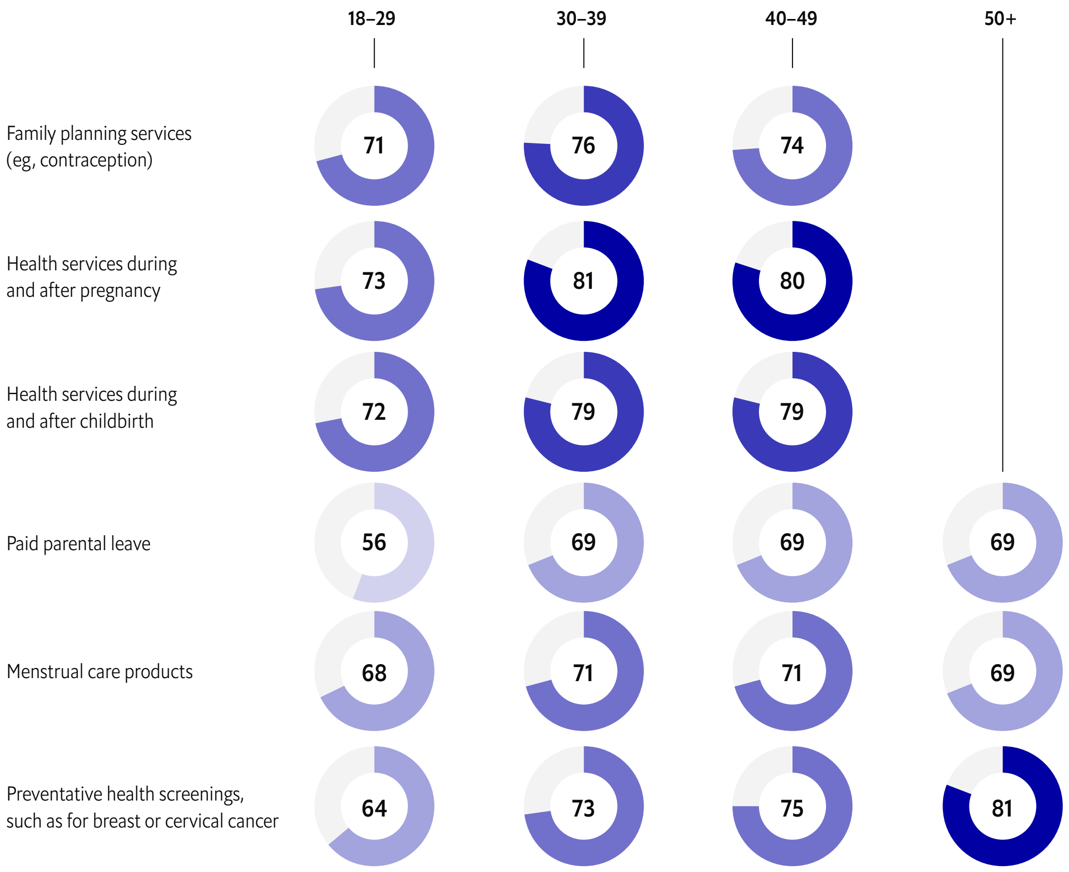
Percentage of survey respondents experiencing the following barriers to healthcare access (%)



Note: Sample size for each group are as follows: men (n = 19,613), women (n = 19,218), non-binary (n = 87)

Figure 22: Availability of relevant women's health services and supports by age

Percentage of women reporting that services are available (%)



Discouragingly, the Index also identifies critical gaps in access to essential women's health supports. Globally, health services that support pregnancy and childbirth (77% and 76% respectively) are more widely available than other women's health supports, including menstrual care products (70%) and paid parental leave (65%).

> **"I'm an expecting mother. When I came [to Germany], I did not know that it's me who has to apply for a midwife, because I have to sell myself as a potential client … they have the option to choose me or not."**

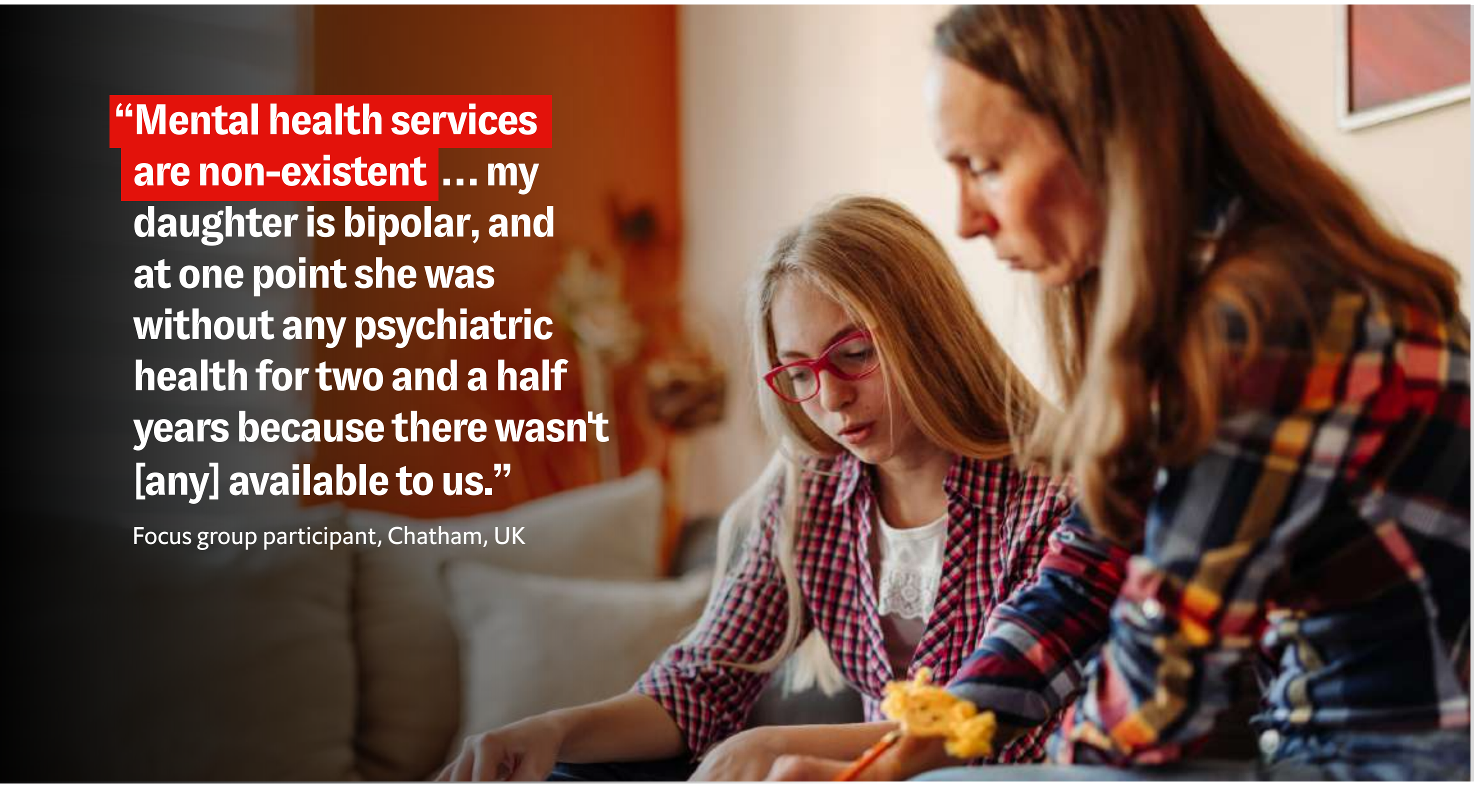
Focus group participant, Munich, Germany

The benefits of closing such gaps are clear. The WHO estimates that over 5mn deaths related to cervical cancer could be avoided by 2050 if preventive healthcare, such as HPV vaccines and cervical screenings, and appropriate treatments were provided to women.[55] Other estimates indicate that the risk of neonatal deaths could be reduced by 34% if mothers received antenatal care.[56] Addressing disparities in outcomes among women requires identifying the unique set of barriers that hinder access to women's health services, as well as ensuring that a woman's age, socioeconomic status, ethnicity, migration status, sexuality or disability status do not impact her ability to achieve good physical and mental health.

Mental health services emerge as another key area where availability is limited. Mental and physical health are two integral and interlinked components of overall wellbeing: depression has been linked to increased risks of cardiovascular disease, diabetes, stroke, chronic pain and Alzheimer's disease.[57] Furthermore, poor nutrition, smoking, limited physical activity and sedentary behaviour can increase risk of mental illness.[58] Therefore, increasing availability of and access to mental health services is critical not just for reaching the estimated one in eight people globally living with a mental disorder, but also for preventing a range of other health conditions that can be costly for individuals and systems to treat.[59]

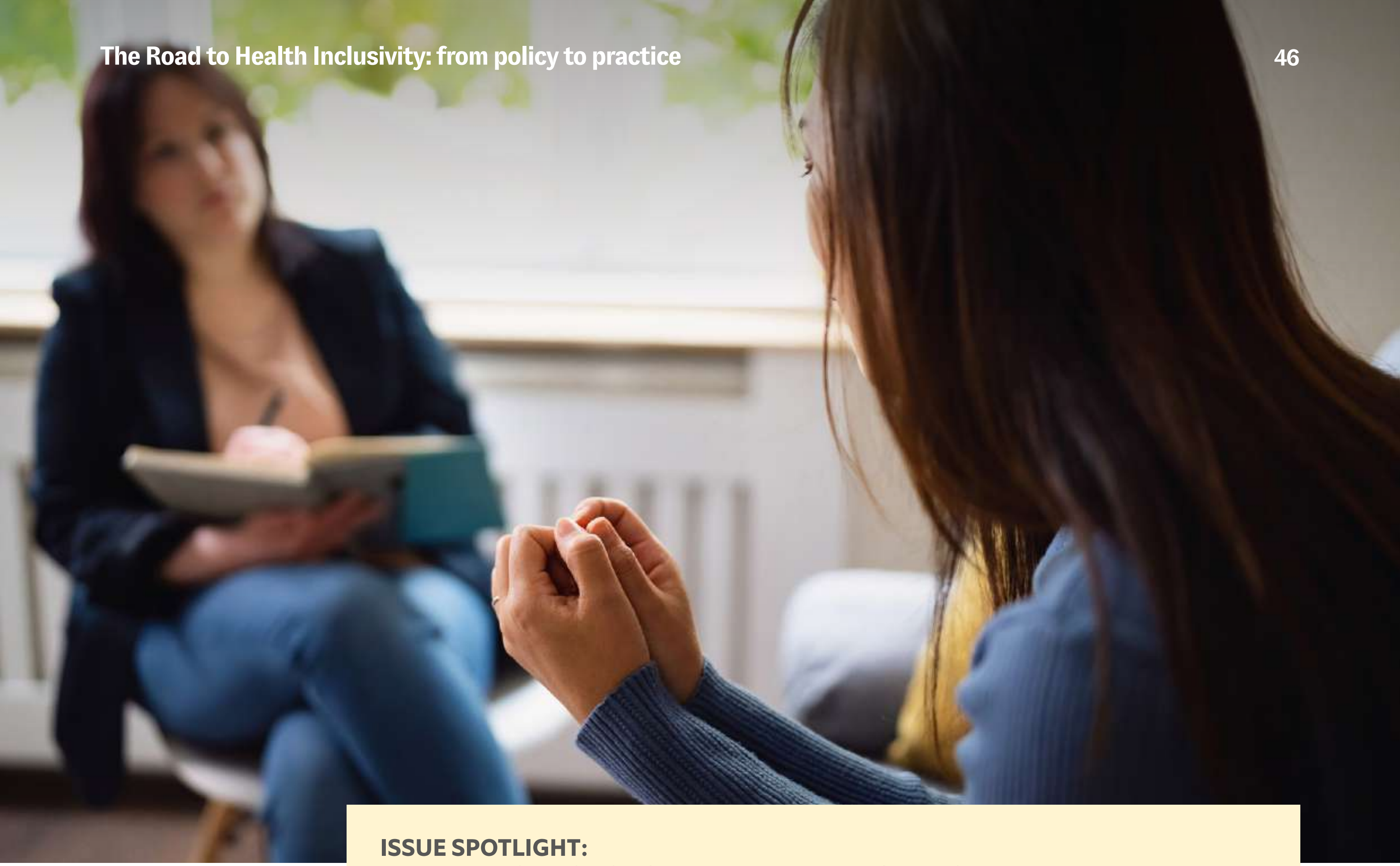
Alarmingly, our survey reveals that one in five respondents globally do not have mental health services available in their community. The access gap between high-income and low- and lower-middle-income countries also persists: 27% of survey respondents in low- and lower-middle-income countries do not have mental health services available in their communities, compared with 13% in high-income countries.

When looking at the availability of mental health services by level of urbanisation, 31% of survey respondents living in rural areas do not have access to these services, compared with 18% living in urban areas. Ms Hutchins explains that the lack of health access in rural areas is not exclusive to mental health support: "The greatest inequities in health access prevail in rural communities because health services and information are not available in a reliable manner. When health systems do not account for socioeconomic and cultural barriers, lack resources to consistently offer consultations, commodities and care, and are unable to meet the expressed needs of communities, trust is eroded, access to care is strained and investment in public health is underutilised."



"Mental health services are non-existent ... my daughter is bipolar, and at one point she was without any psychiatric health for two and a half years because there wasn't [any] available to us."

Focus group participant, Chatham, UK



ISSUE SPOTLIGHT:
THE NEED FOR HOLISTIC HEALTH THAT INTEGRATES MENTAL HEALTH

The demand for mental health services outweighs the current provision, especially as the number of people with mental health conditions increases globally. The covid-19 pandemic alone has led to a 25% increase in anxiety and depression worldwide, with women and younger generations being the worst affected.[60] Younger generations face the additional challenge of navigating fragmented care pathways as they transition from child to adult services, often leading to a disruption in continuity of care and resulting in poorer health outcomes across their lifetimes.[61]

While our research highlights wide gaps in access to mental health services globally, focus group participants spoke of additional challenges they experienced around the diagnosis and treatment for mental health conditions: "If there's a physical impairment ... then they're pretty proactive and they can do the treatment that's required," a focus group participant from Chatham, UK told us. "When it's something a bit more suspect…then I think that's where it falls short."

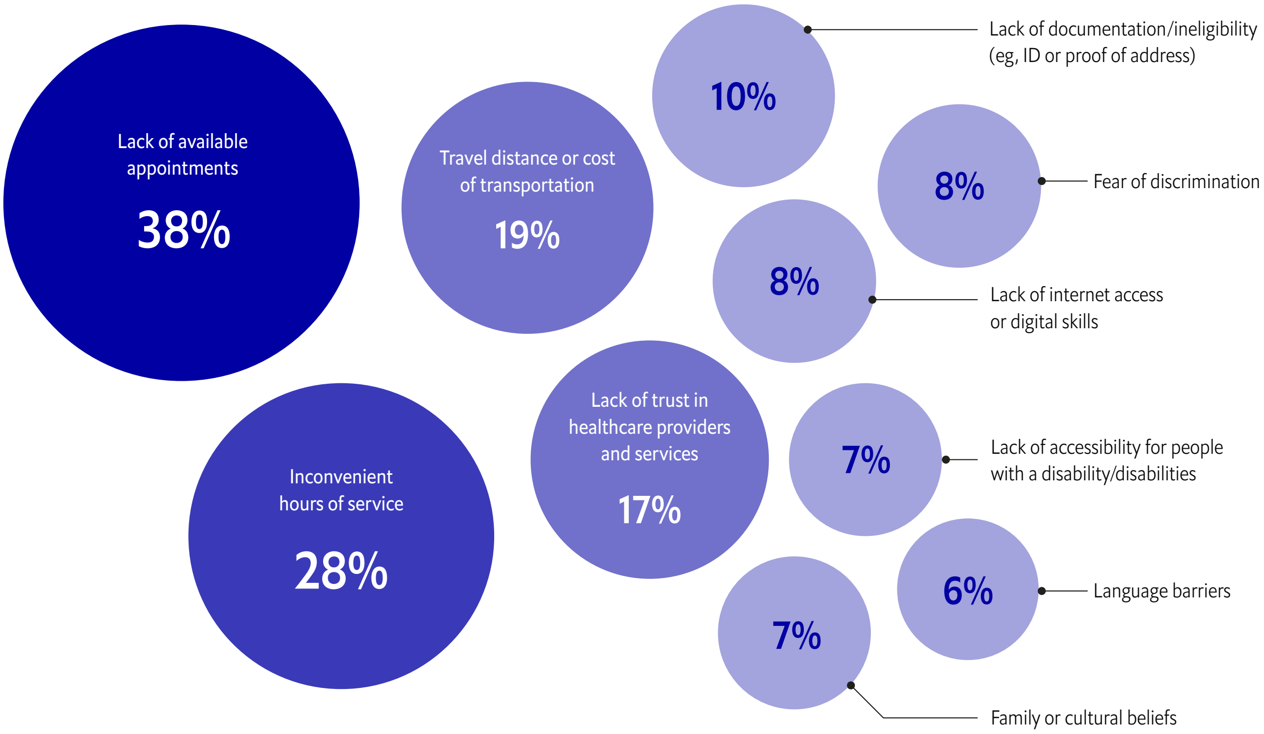
Over the years, the healthcare sector has evolved substantially in its recognition of the importance of mental health, partly driven by greater awareness and support of people with mental health conditions.[62] However, the identification and treatment of mental health conditions present unique complexities, often leading to underdiagnosis or misdiagnosis and, ultimately, delayed treatment. The impact of delayed treatment can be detrimental for people with mental health conditions, who will often go on to experience poorer health and social outcomes.[63]

Increased investment in mental health service provision, training and mental health literacy among healthcare providers is required to increase knowledge of symptoms, reduce diagnostic delays and deliver quality care. As Steve Appleton, President and CEO of Global Leadership Exchange (GLE) explains, "the challenges are partly structural, and partly financial, if we don't invest in the right range of mental health services and they consequently don't exist, then people can't access them. We have been very focused on reactive healthcare, rather than proactively preventative healthcare–that balance needs to change."

An increase in investment into mental health services is a necessary step, but more importantly, the allocation of such investment should proportionately cover the level of population need. This includes investing more in preventive healthcare that provides support systems to the entire population rather than just those with the highest level of mental health needs.

Figure 23: Outside of healthcare costs, over three in five respondents experienced barriers to healthcare access

Percentage of respondents experiencing the following barriers to healthcare access (%)



Availability does not ensure accessibility

Achieving inclusive health systems not only necessitates that services be available, but also that they are affordable, timely and easy to navigate. The Index highlights that, in many countries and for large portions of the population, services do not meet these standards. The percentage of the population spending 10% or more of their income on health ranges from less than 1% in the UAE to a substantial 31% in Egypt. Even more striking, two in five survey respondents (39%) agreed that the cost of seeing a doctor prevents them from seeking healthcare when they need it, while 35% said that they struggle to afford the medications to manage their health conditions.

These findings align with the WHO's estimate that over 90mn people are still being pushed into "extreme poverty" (living on US$1.90 a day or less) because of out-of-pocket healthcare costs.[64] Universal health coverage entails providing financial protection in addition to quality health services. It is critical that countries incorporate mechanisms to protect populations from paying out-of-pocket for health services at the time of use.

> **"At 27 years old I had the first stroke, at 42 I had the second, and shortly after coming here I had the third stroke and went into a coma. I was in a really bad condition. And it is [hard], because we do not have resources; although we had farms ... we had to sell them, also a car."**

Focus group participant, Manaus, Brazil

Cost is not the only barrier to accessing healthcare services. More than three in five respondents encounter at least one other key obstacle—including lack of appointments, inconvenient hours of service, lack of digital skills and language barriers—that make it difficult to see a doctor or access other healthcare services in their community.

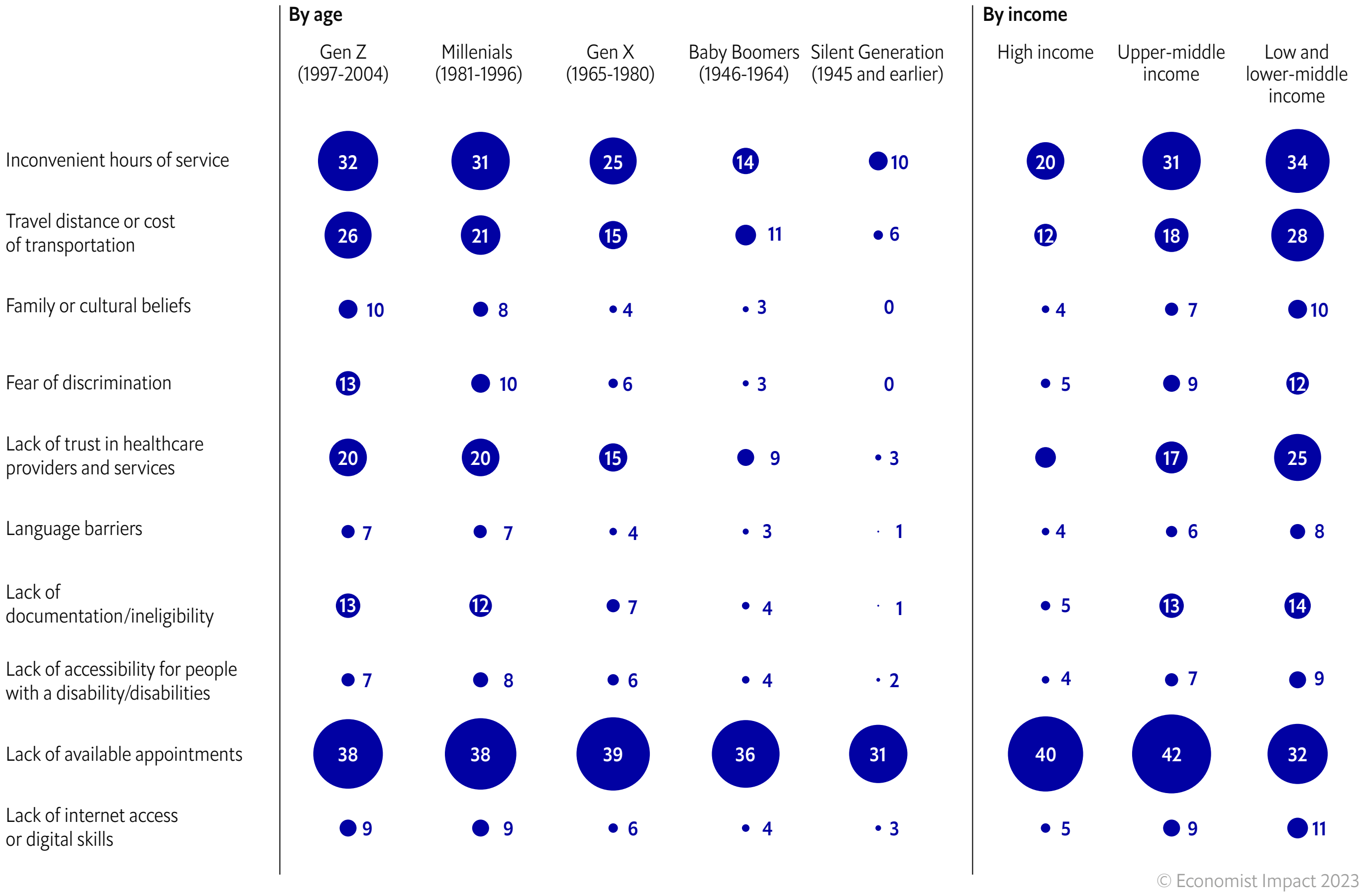
Interestingly, the types of barriers that individuals are most likely to confront are not consistent. In high-income countries, the primary obstacle is lack of available appointments, whereas travel distance and inconvenient hours of service were cited as key barriers in low- and middle-income countries. Age is also a factor when examining the likelihood that an individual will face roadblocks to healthcare: younger people report facing more obstacles on average.

Over two in five respondents (43%) under the age of 50 said that the cost of healthcare services prevents them from seeking healthcare when they need it, compared with just 28% of respondents aged 50 and above.

Overall, these findings underscore that availability of services is only one piece of the puzzle. Ensuring meaningful access to healthcare services is a crucial component in building more accessible and inclusive systems. It is in the best interest of governments to act quickly, as inaccessibility or delayed access to services can be costly for both individuals and societies. For example, delayed access to healthcare can result in higher rates of morbidity and mortality, especially for individuals with pre-existing conditions, ultimately increasing healthcare costs.[65,66]

Figure 24: Barriers to healthcare access (outside of healthcare costs)

Percentage of respondents experiencing barriers to healthcare by age and country income group (%)



	By age					By income		
	Gen Z (1997-2004)	Millenials (1981-1996)	Gen X (1965-1980)	Baby Boomers (1946-1964)	Silent Generation (1945 and earlier)	High income	Upper-middle income	Low and lower-middle income
Inconvenient hours of service	32	31	25	14	10	20	31	34
Travel distance or cost of transportation	26	21	15	11	6	12	18	28
Family or cultural beliefs	10	8	4	3	0	4	7	10
Fear of discrimination	13	10	6	3	0	5	9	12
Lack of trust in healthcare providers and services	20	20	15	9	3		17	25
Language barriers	7	7	4	3	1	4	6	8
Lack of documentation/ineligibility	13	12	7	4	1	5	13	14
Lack of accessibility for people with a disability/disabilities	7	8	6	4	2	4	7	9
Lack of available appointments	38	38	39	36	31	40	42	32
Lack of internet access or digital skills	9	9	6	4	3	5	9	11

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Access to health information

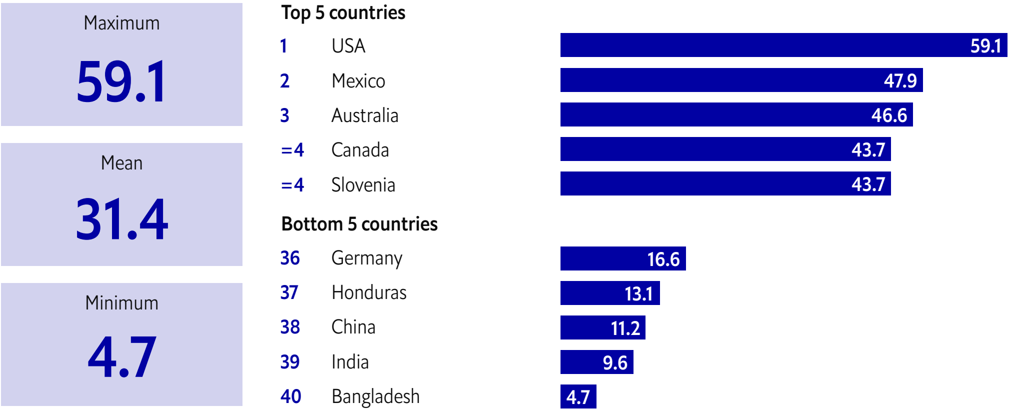
Access to reliable and appropriate information about health and wellbeing is essential to ensure that individuals are equipped with the right knowledge, beliefs and skills to maintain healthy lifestyles and manage their health conditions. The ramifications of not having access to reliable health information can be severe. Low health literacy is associated with increased hospital admissions, lower use of preventative services, poorer disease self-management, and higher mortality and health costs.[67] As such, it is important that both information provided by health professionals and other health materials are offered in a format that is easy to interpret and accessible to diverse audiences.

Our survey shows that almost one in three respondents (29%) do not feel that they have access to useful and trustworthy information about a range of core health issues—including mental health, dental health, sexual and reproductive health, and health and lifestyle (see Figure 25).[XIII] The same proportion do not feel that they are given advice or information on how to care for their health at home, and 27% do not feel that doctors and other healthcare providers discuss their health in a way that they understand.

Figure 25: Top- and bottom-scoring countries on Access to health information

Indicator 3.3.7 Access to health information

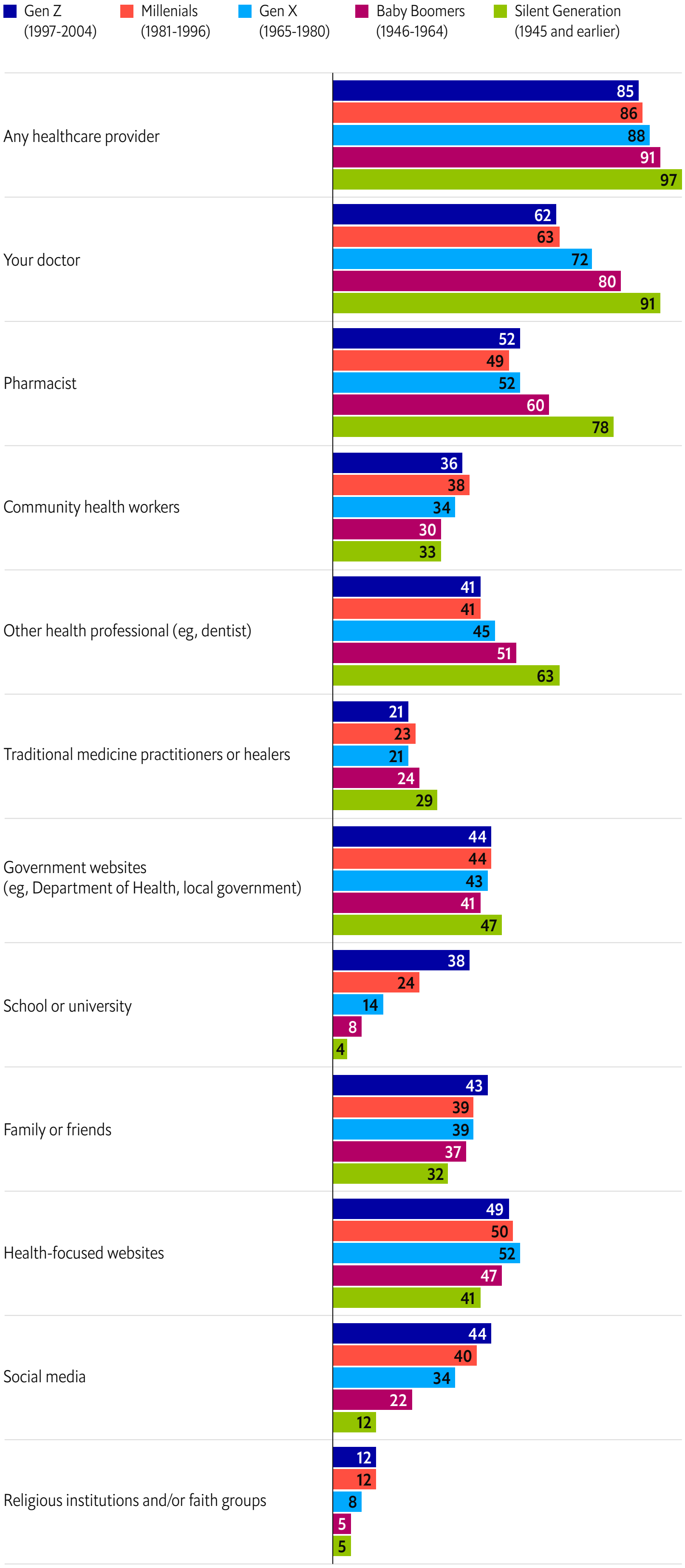
Percentage of respondents who feel they have adequate access to information about a range of health topics (%)



[XIII] This figure is the average percentage of respondents indicating that they do not have access to or are not sure if they have access to useful and reliable information about a range of essential health topics covered by the survey: health and lifestyle; mental health; dental health; sexual and reproductive health; preventative screenings; alcohol, tobacco and drug use; and healthcare services available in their community.

Figure 26: Trusted sources of health information by generation

Percentage of population indicating that each of the following provide trustworthy information about health (%)



Although doctors emerged as the most common source that people turn to for health information, nearly one in three respondents (32%) do not feel that they can turn to their doctor for useful and trustworthy information. There are a wide variety of explanations for this lack of trust. A focus group participant in the UAE noted that physicians are often overbooked and do not have time to answer patient questions: “Some doctors feel like explaining whatever they are doing. Others, don’t do that. Sometimes, because of the pressure they are under and [the high number of cases], they have to finish many cases in a certain period of time.”

Focus group discussion participants in the US felt that the commercialised nature of the country’s healthcare system diminishes trust in physicians: “Sometimes appointments feel somewhat transactional. [Doctors] are recommending medications and procedures, and you don’t know if you really need it or if they are getting something out of it … like a kick-back.” Respondents also frequently cited pharmacists (52%), health-focused websites (50%) and other medical professionals (such as dentists) (44%) as other sources of reliable and trustworthy information.

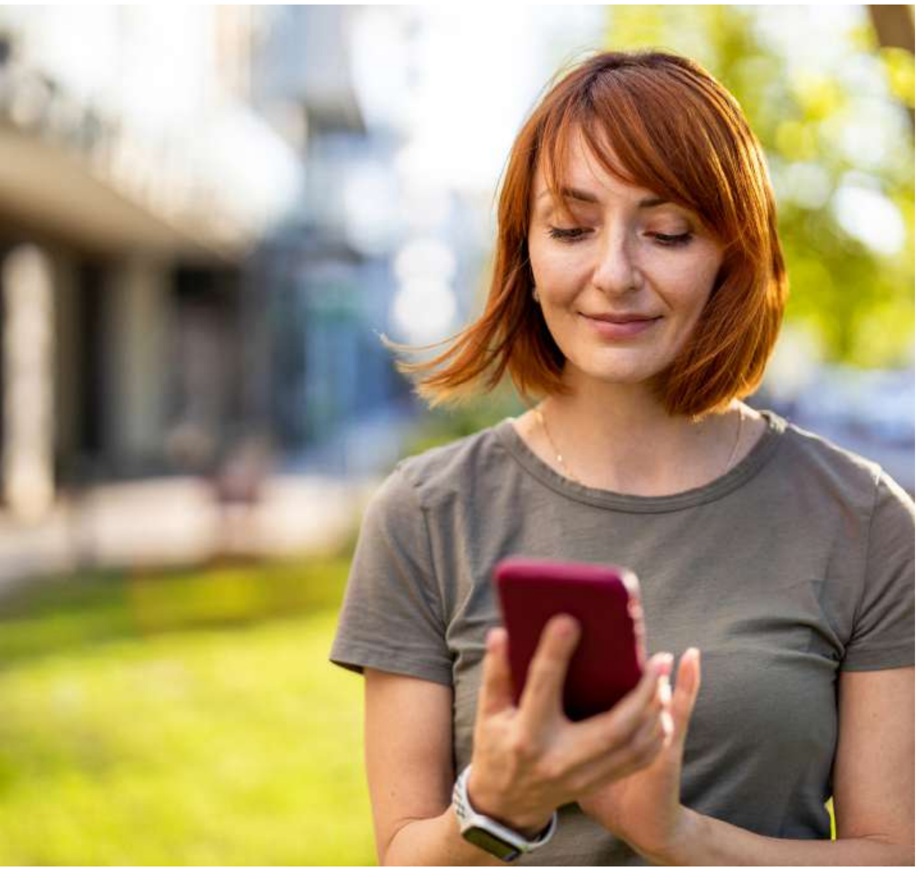
Younger generations were less likely than older cohorts to state that doctors and other medical professionals were a useful and trustworthy source of information (see Figure 26).[XIV] The reverse is true for information from sources other than a healthcare provider: younger generations more frequently cited social media as a trustworthy source of health information.

[XIV] Younger generations include Generation Z and Millennials; older cohorts include Generation X, Baby Boomers and the Silent Generation.

The use of social media when it comes to information about health and healthcare can be a double-edged sword. It is well documented, for instance, that misinformation circulated across various social media platforms during the covid-19 pandemic had an adverse impact in terms of vaccine hesitancy and uptake; however, many of the same studies proposed that social media can also be used by health authorities to counteract misinformation, debunk myths and respond to individuals' concerns.[68]

Focus group participants spoke of how social media can also expand individuals' access to a larger community facing similar health concerns, particularly for those living in more isolated areas or experiencing rarer health conditions. Hence, governments should take care to address the risks of social media as a source of health information, while investigating how digital spaces can be further leveraged to overcome isolation and build community.

Although general information and knowledge about health is indispensable, access to information highlighting specific risks known to have a greater impact on certain populations is also an important factor to consider. Genetic differences, family history, and behavioural and socioeconomic characteristics can place certain subpopulation groups at increased risk for some diseases and health conditions.[69] Furthermore, different cultural, religious and ethnic characteristics can also impact beliefs and behaviour when it comes to health and illness.[70] Despite these benefits, we found that just under half of survey respondents (46%) have not had a doctor or other health professional provide them with information about health risks specific to their background.



"When it comes to support … social media is quite a big one for me … there are lots of forums and stuff for specific diseases and things like that. It's good for support with other people that are in the [same] situation … does anyone ever get this symptom? Have they tried this medication?"

Focus group participant, Chatham, UK

ADDRESSING THE CHALLENGES

Investing in prevention: Health systems around the world have historically focused on treatment instead of prevention. However, greater emphasis on prevention and health promotion not only enables individuals to take ownership of their health, it is also more cost-effective.[71] One study found that increasing the use of evidence-based, clinical prevention services to 90% could save 2.3mn lives and US$3.7bn per year in the US.[72] Prevention interventions often include both education about health conditions and lifestyle choices, and promote access to the resources and tools to implement changes effectively, but need to be available and accessible to the entire population to ensure gaps in access are not perpetuated.

Addressing barriers to healthcare access: Some countries have introduced a range of accessibility features and supports that can help individuals to overcome healthcare barriers. Such features include home visits and delivery of medications, free transportation services, and flexible appointments or extended hours. These types of services can be particularly useful in overcoming barriers that are more likely to affect specific segments of the population. Focus group participants in the US indicated that some rideshare services provide a set number of free rides each year for those needing transportation to healthcare appointments. More substantially, countries such as Luxembourg[73] and Malta[74] have made all public transit free of cost for residents, helping to reduce transportation barriers overall.

Leveraging digital tools: Online health information should be available in multiple formats and languages, and accessible to a variety of audiences. Strategies for creating accessible health information include using plain and simple language to enhance comprehension, and presenting information in multimodal or interactive formats to ensure that individuals with different learning preferences can understand and engage with the content. In addition, creating programmes for improving digital health literacy serves to increase health knowledge and help individuals to identify reputable health information online.

Leaders in implementation

Social media can be a useful tool for healthcare stakeholders to share health-related messages and combat misinformation. During the covid-19 pandemic, the US Centers for Disease Control and Prevention (CDC) created the "We Can Do This" campaign, utilising various social media platforms to share information with the public and dispel misinformation.[75] The campaign included animated videos, easy-to-understand infographics, and online community events that allowed participants to ask questions and health professionals to quell concerns related to covid-19.

Health inclusivity among society's most vulnerable

It is well documented that some people are more vulnerable to exclusion from the systems and structures that promote good health.[76,77,78] A combination of systemic, socioeconomic, environmental and cultural factors often drives this exclusion.

These "hard to reach" populations can have differential access to basic living standards, housing and education–social determinants of health which can enable or hinder the ability to live a healthy life. Lower access for these populations creates and sustains health inequities. They can also face larger hurdles when trying to manage or enhance their health, while being less likely to have their unique needs, interests and preferences accounted for by health systems and services.[76,77,78]

93% of countries have taken steps to establish health as a basic right for all individuals living within their territory; however, critical gaps persist.

Building appropriate and culturally sensitive systems of care

The Index assesses national-level efforts to identify vulnerable population groups and support their access to appropriate and culturally-sensitive care. Most countries have introduced some measures to support these efforts: 93% of governments have taken steps to establish health as a basic right for all individuals living within their territory. Almost every country in the Index—Russia and Algeria are exceptions—has introduced measures specific to vulnerable populations, including strategies or policies that address health inequities and health-related policies for specific populations such as children and indigenous peoples.

However, critical gaps persist. More than half of countries (58%) do not include cultural competency in training programmes for healthcare providers. And, discouragingly, eight countries have policies or regulations explicitly restricting access to healthcare systems based on characteristics like migration status.[XV] Survey respondents who identified as migrants are more likely to report having been denied access to healthcare (32%) than the rest of the population (19%).

[XV] This finding is based on research conducted in the spring and summer of 2022 and does not account for potential changes to legislation or policy after that date.

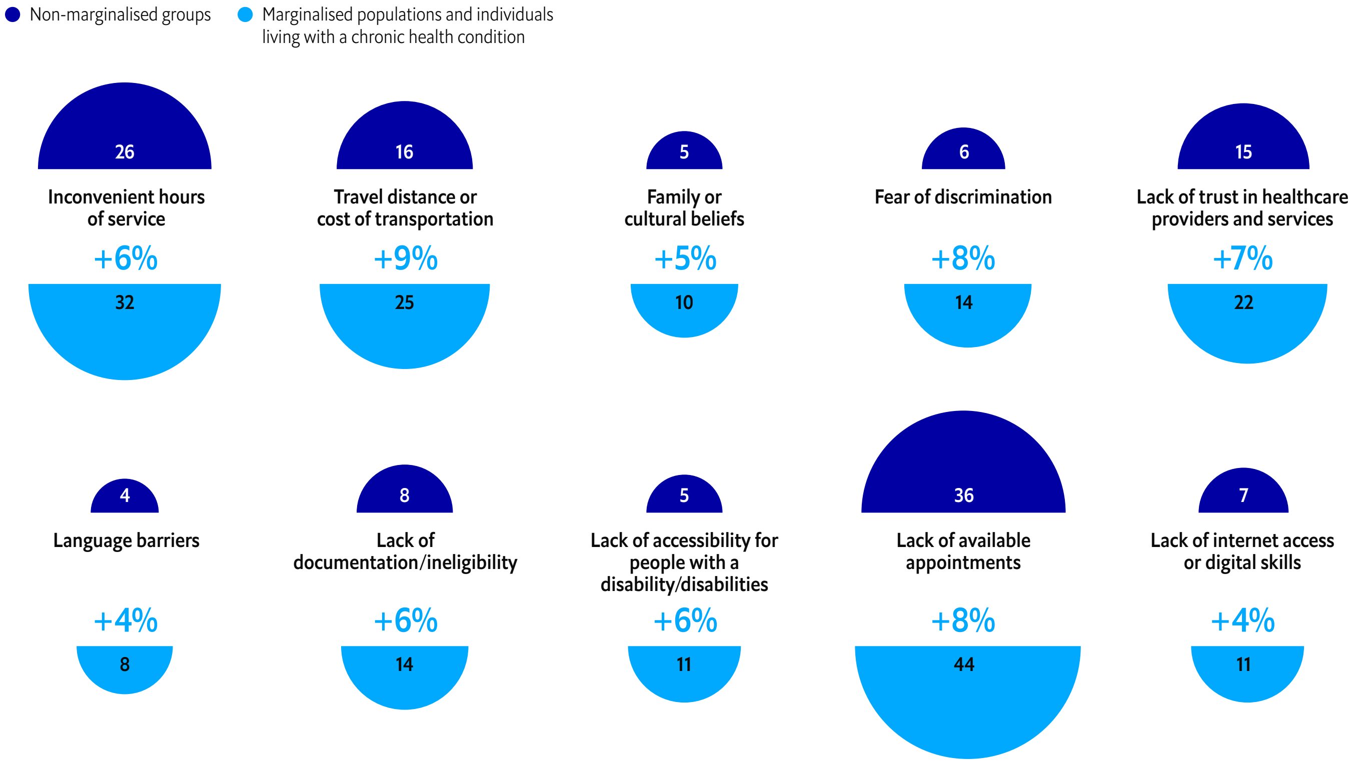
Barriers to healthcare access

According to our research, marginalised populations and individuals living with a chronic health condition are 10 percentage points more likely to report having been denied access to healthcare services than non-marginalised groups. Furthermore, they are 17 percentage points more likely to have experienced at least one of a range of barriers when seeking healthcare (see Figure 27).

Marginalised populations and individuals living with a chronic health condition are 10 percentage points more likely than non-marginalised groups to report having been denied access to healthcare services and 17 percentage points more likely to have experienced barriers related to seeing a doctor or accessing other healthcare services.

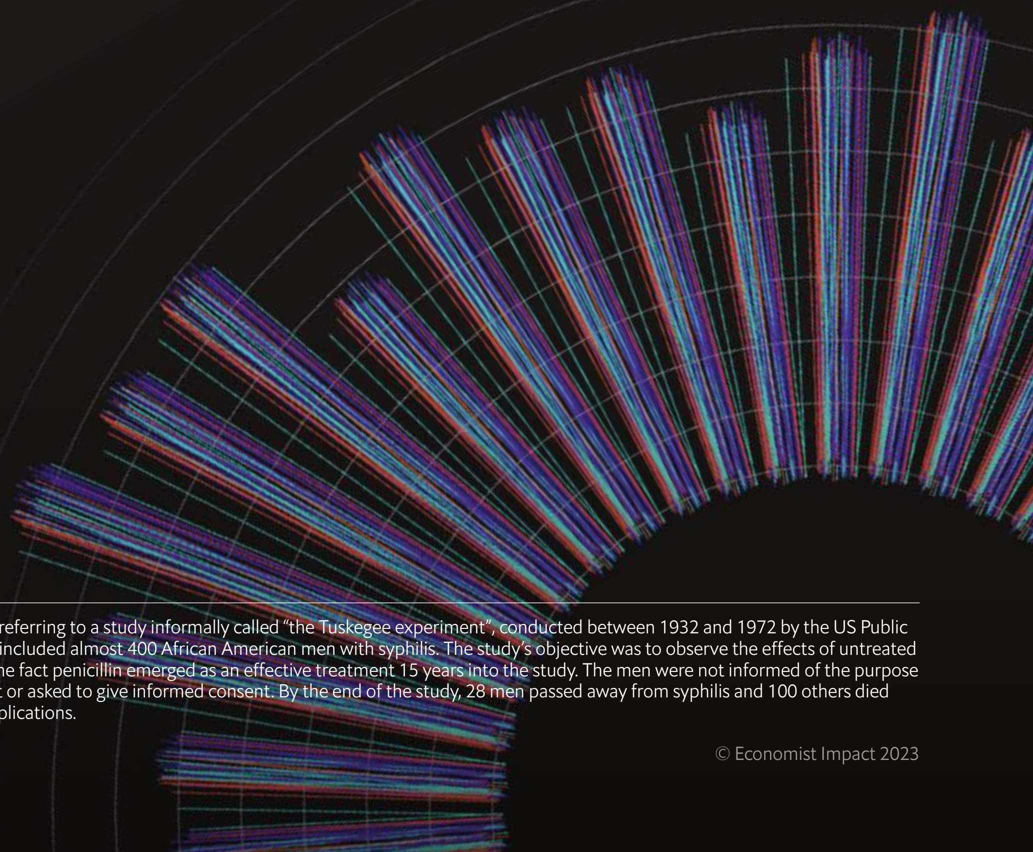
Figure 27: Barriers to healthcare access (outside of healthcare costs): marginalised populations and individuals living with a chronic health condition and non-marginalised groups

Percentage of respondents experiencing each of the following barriers (%)



> **“People of colour already have a level of distrust —we know about things like Tuskegee and how we’ve been part of clinical trials [in the past] and so how do we know that this is not that? It goes back to the mistrust people already have in the healthcare system.”[XVI]**

Focus group participant,
Washington DC, US

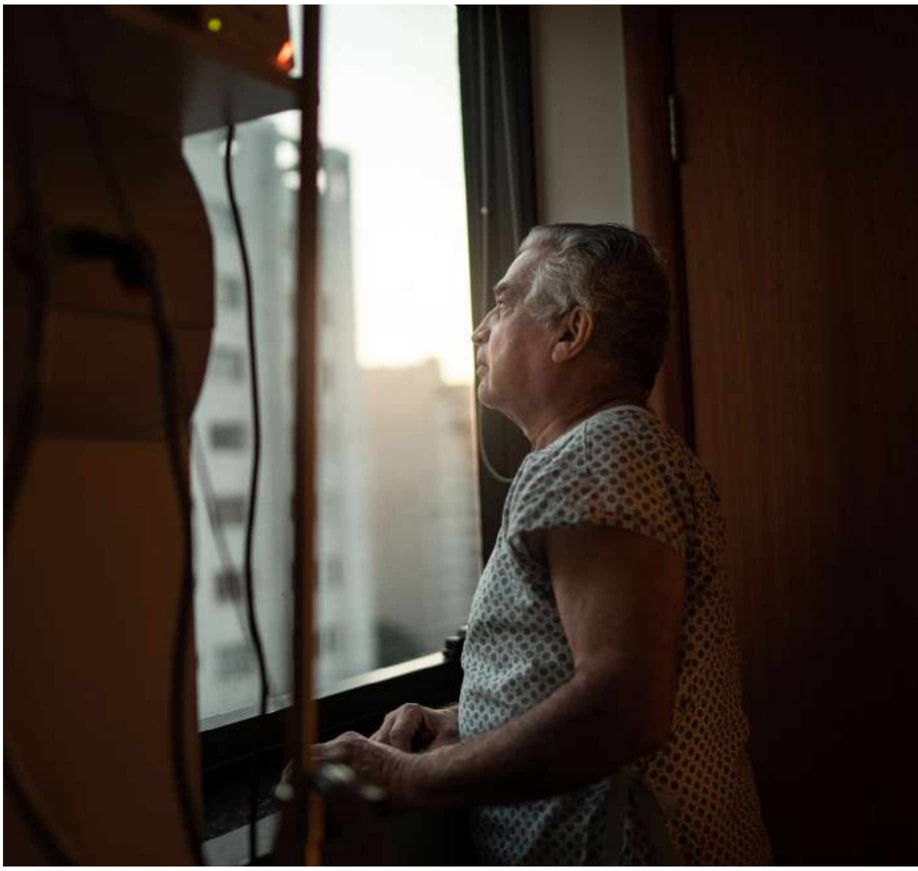


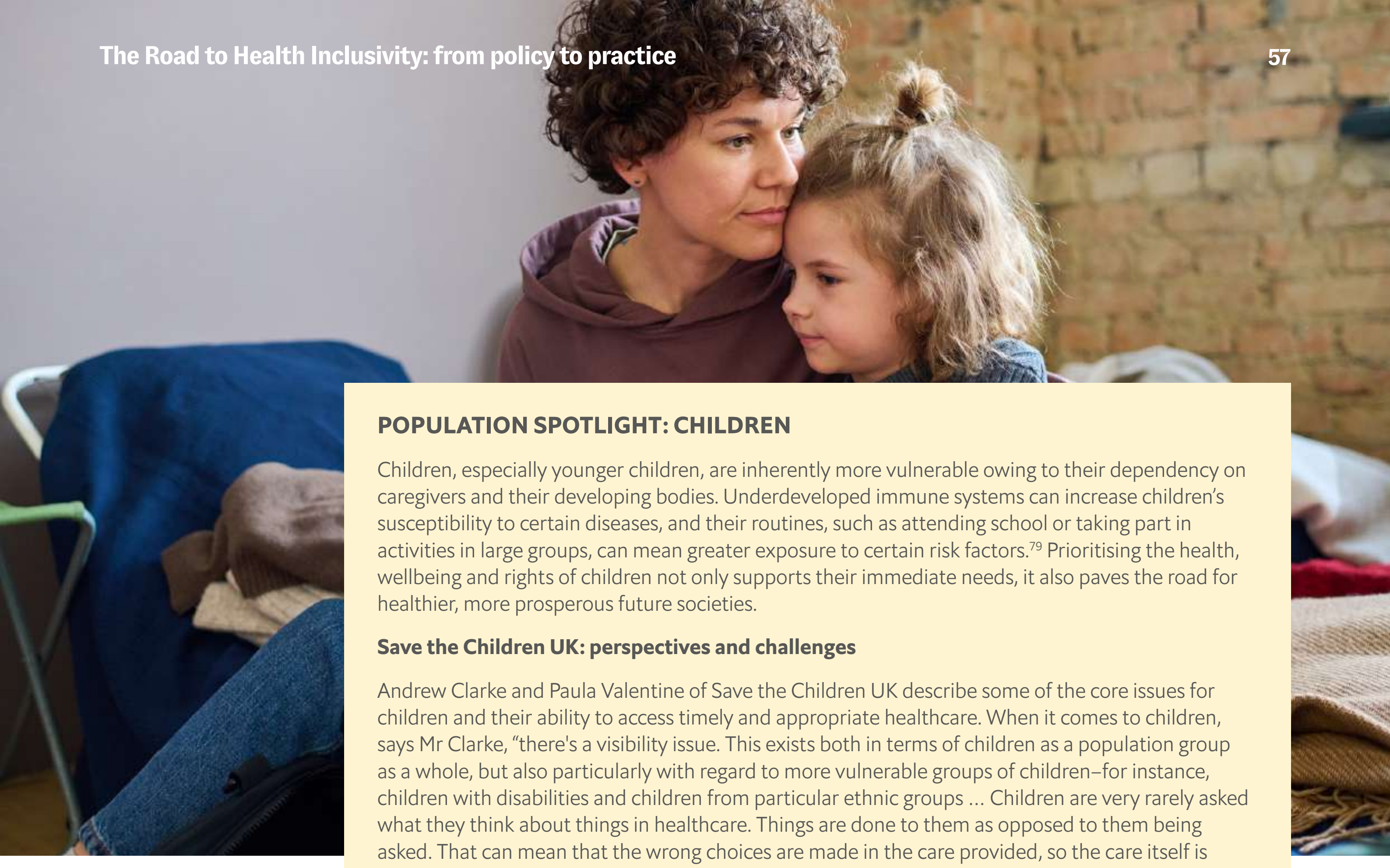
[XVI] The participant is referring to a study informally called “the Tuskegee experiment”, conducted between 1932 and 1972 by the US Public Health Service. It included almost 400 African American men with syphilis. The study’s objective was to observe the effects of untreated syphilis, despite the fact penicillin emerged as an effective treatment 15 years into the study. The men were not informed of the purpose of the experiment or asked to give informed consent. By the end of the study, 28 men passed away from syphilis and 100 others died from related complications.

Marginalised populations and individuals living with a chronic health condition are more likely to experience financial barriers to maintaining their health, establishing a cycle that reinforces existing drivers of health inequities. In our survey, these groups were 10 percentage points more likely than non-marginalised groups to indicate that the cost of healthcare has made it harder to pay for other basic necessities such as housing or food (43% versus 33%) and 11 percentage points more likely to struggle to afford medications needed to manage health conditions (42% versus 31%).

Among the marginalised groups dicussed in this report, refugees, asylum seekers and displaced persons are the most vulnerable: nearly nine in ten (89%) experienced at least one key barrier that made it difficult for them to see a doctor or access other healthcare services. Nearly one in three respondents from this group (32%) also highlighted a lack of documentation or ineligibility as a barrier limiting their ability to see a doctor or access other healthcare services, compared with 8% of non-marginalised groups.

> **“The doctor treated me, but I had to sell the car to be able to … And still among us we ask God to help us, Venezuela, in health matters.”**
>
> Focus group participant
> (migrant from Venezuela), Brazil





POPULATION SPOTLIGHT: CHILDREN

Children, especially younger children, are inherently more vulnerable owing to their dependency on caregivers and their developing bodies. Underdeveloped immune systems can increase children's susceptibility to certain diseases, and their routines, such as attending school or taking part in activities in large groups, can mean greater exposure to certain risk factors.[79] Prioritising the health, wellbeing and rights of children not only supports their immediate needs, it also paves the road for healthier, more prosperous future societies.

Save the Children UK: perspectives and challenges

Andrew Clarke and Paula Valentine of Save the Children UK describe some of the core issues for children and their ability to access timely and appropriate healthcare. When it comes to children, says Mr Clarke, "there's a visibility issue. This exists both in terms of children as a population group as a whole, but also particularly with regard to more vulnerable groups of children–for instance, children with disabilities and children from particular ethnic groups … Children are very rarely asked what they think about things in healthcare. Things are done to them as opposed to them being asked. That can mean that the wrong choices are made in the care provided, so the care itself is often less effective, but it also often means that children's experiences can be quite poor. … Very few health services and systems actually provide child-appropriate or child-rights-based aspects of care [or feed] data and opinion for children from children into quality of care improvement cycles."

> **"Children from certain parts of society are even less visible, or invisible."**
>
> Andrew Clarke, Senior Health Advisor, Save the Children UK

So what can we do? Some countries have made progress on representing children and young people in monitoring the quality of healthcare and taking their views into consideration for higher-level decision-making—although, as Mr Clarke emphasises, such measures, "are still quite embryonic in most settings." For example, several countries have established children's parliaments where older children are engaged, consulted and appear at forums to represent their views.

Ms Valentine emphasises how NGO-led initiatives, often in partnership with governments, have also been successful at advancing children's voices and views. Save the Children has integrated approaches into some of its country programmes to give greater visibility to children's healthcare-related perspectives. Social accountability mechanisms provide opportunities for young people and the caregivers of young children to provide feedback on quality of care and attitudes of health workers.

Ms Valentine explains, "When we have talked to children and their families over the past 20 years the fundamental things that matter are consistently similar. In most cases, it's simple things like being greeted, being treated with respect, being able to give birth in a traditional position and not a position that's uncomfortable, not being abused, and being informed about the outcome."

"The irony is that these are things that actually don't cost very much [to address], if anything, at all," adds Mr Clarke.

Although substantial progress has been made in advancing clinical competencies for health workers, improving patient communication has been slower. "Health workers don't really have the opportunity to practise [patient communication] skills until they get into the health facility and start their consultations," says Mr Clarke. "There was a big shift in global standards about five years ago when the WHO published new standards that give equal prominence to the experience of care and the fulfilment of basic child rights, alongside more traditional standards related to drugs, care, and equipment for children and adolescents. But it takes many years for this to filter through and to change how health workers work and think in the systems they operate in. And so, there's optimism there, but it will take a while."

Health-sector discrimination against vulnerable groups

Our study supports previous research showing that certain vulnerable groups are more likely to face discrimination in healthcare.[80,81,82] We found that marginalised populations and individuals living with a chronic health condition were 8 percentage points more likely than non-marginalised respondents to feel that they have received unfair treatment or that they have been discriminated against when interacting with healthcare providers (27% versus 19%). Furthermore, these groups were 9 percentage points more likely to say that their pain and health conditions have not been taken seriously by providers, and equally more likely to have been denied tests or treatments that they believed would have been beneficial to their health (31% versus 22%).

Marginalised populations and individuals living with a chronic health condition were 8 percentage points more likely than non-marginalised groups to feel that they had received unfair treatment or that they had been discriminated against when interacting with healthcare providers.

Such findings are particularly problematic in the light of evidence that some marginalised or minority population groups are more likely to receive delayed diagnosis or be misdiagnosed.[83,84] A study conducted in the US found that bipolar disorder in African Americans is more likely to be misdiagnosed as another disease (such as schizophrenia) than in persons of non-African ancestry.[85] Other research suggests that ethnic minority persons in the UK are more likely to reach dementia services at a later stage in their condition than their ethnic-majority counterparts.[86]

Focus group discussion participants highlighted that services are not often tailored or sensitive to their specific needs. One participant who identified as LGBTQ+ captured this challenge well: "For so many of us, we want to see someone who looks like us and understands our sexuality. You may not open up all the way to a provider that doesn't understand your lifestyle." Another participant cited similar concerns around mental health services: "I've been unable to access healthcare providers—especially mental health providers—that I feel comfortable with or that have experience with certain issues." Studies have shown that empathy in healthcare is critical: "Patients are more likely to follow their treatment plan and practise self-care when they feel heard and understood," writes one expert.[87]

Addressing these disparities will require broad and systemic reforms—including training on cultural competency and implicit bias, and the implementation of strong anti-discrimination measures within the health sector and beyond. Improvements must not only work towards breaking down present-day barriers, but also aim to address enduring legacies of exclusion and mistreatment that can impact help-seeking behaviour.

> **"For people who may not know the doctor personally, the wait is long, no prompt actions are taken, and we aren't heard. If you have connections or know someone, they will admit you immediately, but if people like us inform them that we are in severe pain, they still won't admit us."**
>
> Focus group participant, Delhi, India

Individual agency is required when systems fail vulnerable populations

Many focus group discussion participants expressed their frustrations over the complexity of healthcare systems. In the UK, the process of being passed between provider types because of complicated referral processes is a primary concern. "I spoke to them for the assessment ... and they said, 'Sorry we can't help you. We're a short-term service. You need long-term help," one participant told us. "I didn't get signposted to go somewhere else. Didn't get referred back to [my doctor]. It was just like, 'you do need help, but we can't help you.'" These risks can be particularly acute for migrant populations, who encounter additional challenges in navigating unfamiliar systems, are exposed to poor quality care and sometimes face language barriers.

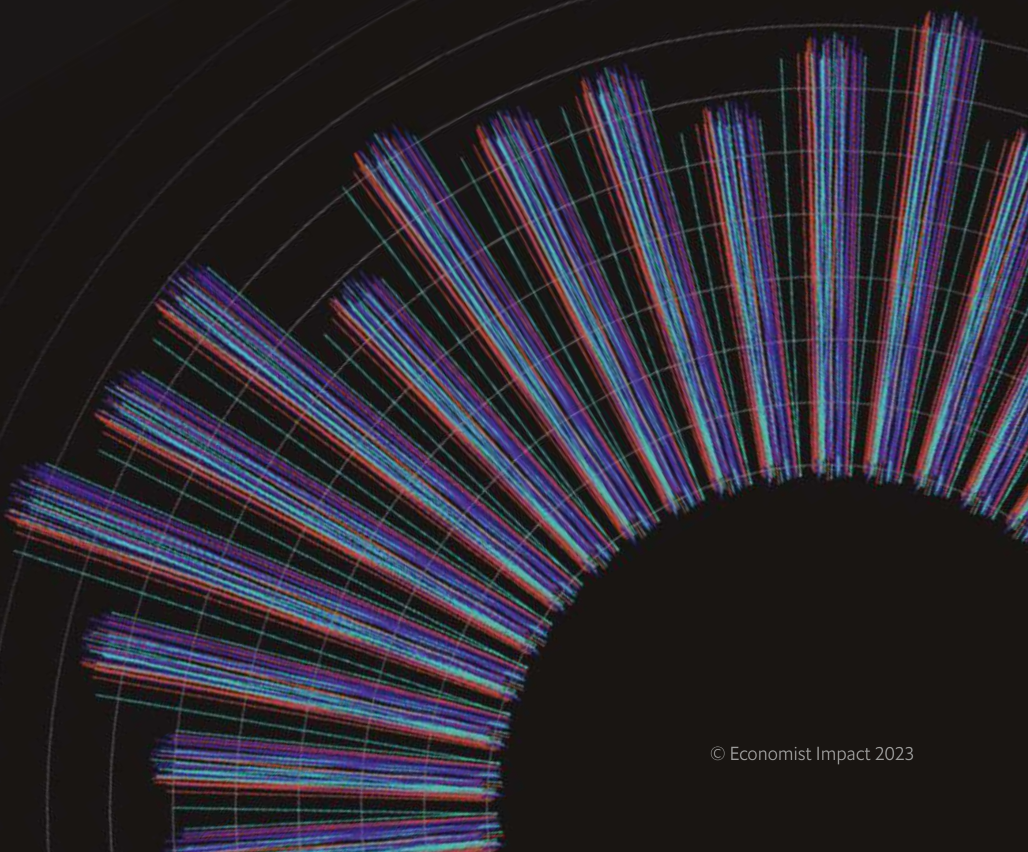
> **"I think it is because they feel there is nothing you can do to them. They will still get paid and you will go home. Recently I took my child to the clinic and one of them asked me what I was doing there, yet the child was still in pain. He told me he was done with me and that I was wasting other patients' time. I was still breastfeeding but he told me to go outside, [either to] the streets or my house. But the private hospitals will treat you well because you have paid them money."**
>
> Focus group participant, Nairobi, Kenya

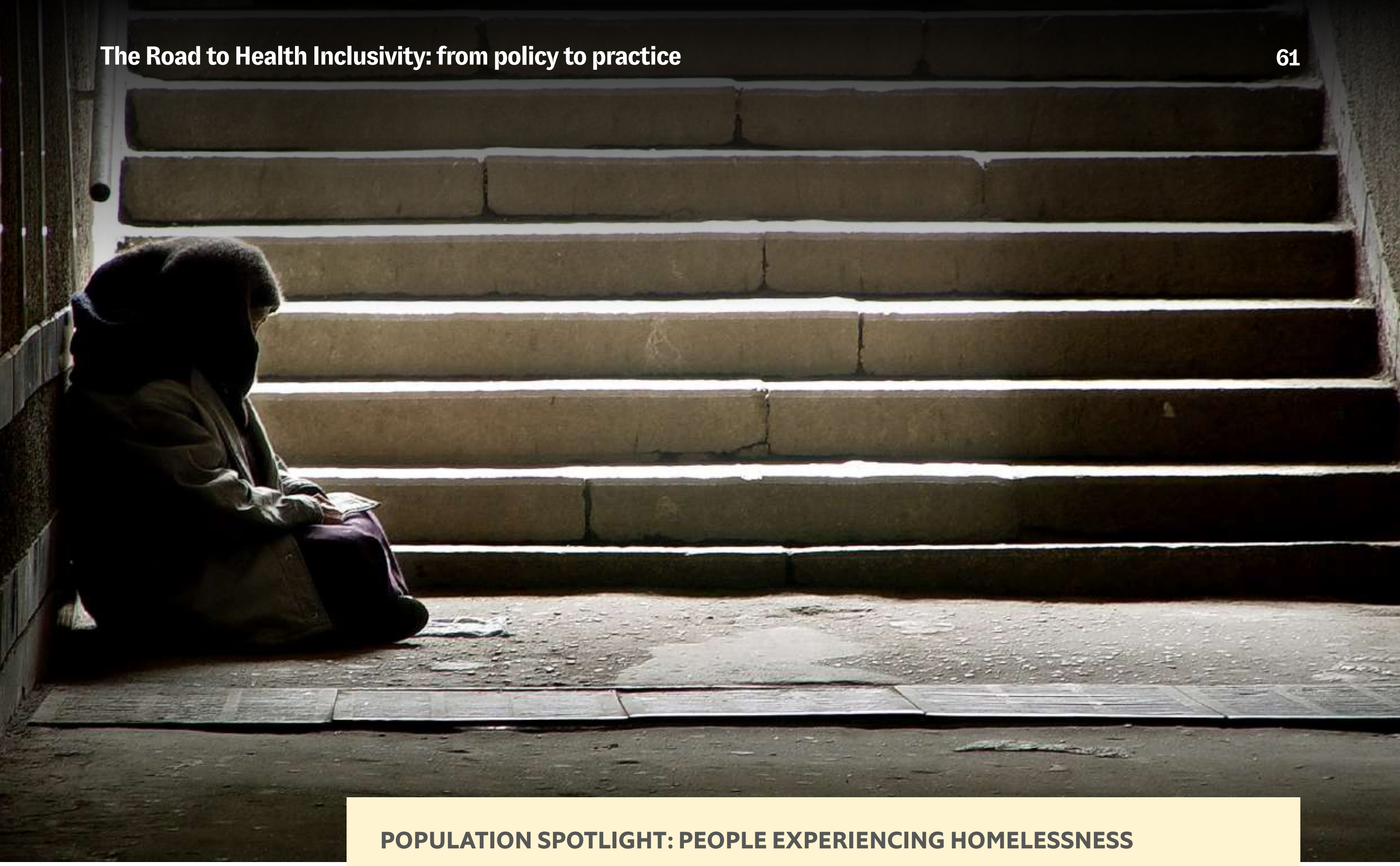
In many cases, participants spoke about how the ability to access the care they needed depended on their personal determination and ability to self-advocate. "I went in once because I had terrific pains in my legs and [my doctor] said, 'oh, it's just your age'," a participant in a focus group discussion with persons with disabilities told us. "And I said, 'I don't think so, it's horrendous.' And she took me for x-rays and it turned out that I had no cartilage in my knees, and she apologised and sent me to the right people after that. I'm quite vocal, I will stand up for myself, but ... people, especially with mental health [issues], they're not going to speak up for themselves. [They] just get left behind." A US-based participant explained, "[The insurance company] denies everything. I send all of the paperwork that I am supposed to and they still deny it. So you either have to fight with them or you have to pay so much money for something that should not cost so much, which is absolutely crazy."

Although convoluted health systems can be a challenge for all individuals, some vulnerable groups and marginalised populations have complex health needs that can put them in contact with health systems more frequently or require specialised care.[88,89] Furthermore, the ability and agency to self-advocate may be more limited for marginalised populations or those with other vulnerability characteristics that may face greater physical, mental, social or economic constraints.

> “I believe there is a need for more information about the healthcare system, even though there is a free public system. Knowing the different prices of private health plans, to see if there is an affordable policy for us—that would be helpful.”

Focus group
participant,
Manaus, Brazil





POPULATION SPOTLIGHT: PEOPLE EXPERIENCING HOMELESSNESS

International estimates suggest that over 100mn people are homeless worldwide.[90] UN-Habitat, the UN agency that focuses on urban development and human settlements, reports that one in four people are living in conditions that are harmful to their safety, health or security, while 15mn people are forcefully evicted every year.[91] People who have experienced homelessness have a heightened risk of illness or premature death[92]. Furthermore, being on the street—even for a few days—can cause trauma and increase the likelihood of mental health issues.[93] Substance abuse is another key risk point, both as a cause and consequence of homelessness.[93]

The Institute of Global Homelessness: perspectives and challenges

"Although systems might differ from country to country, if you're homeless it's likely that you've been failed by multiple systems," says Julia Wagner, Programme Director at the Institute of Global Homelessness. "And if people have been on the street for a long time, it is likely that they have had lots of negative interactions with different systems and also hospitals." One of the biggest challenges that Ms Wagner identifies is the inaccessibility and insensitivity of health-related systems for the homeless population. "Healthcare systems are not built for people experiencing homelessness," she says. "For example, systems may require documentation that homeless people may not have access to. It's also really important that systems understand the full spectrum of individuals' unique needs, because a lot of times homeless people are kind of treated as a bloc."

So what can we do? "Homelessness should be treated with urgency and as a public health emergency," says Ms Wagner. "The longer someone lives on the street, the more likely they are to have multiple conditions that need support. The best thing to support the health of homeless people is to provide self-contained housing with supportive services as soon as possible and prevent homelessness before it occurs." Investments in mental health support, harm reduction and trauma-informed care are essential to ensuring that hospitals and social workers are trained to respond effectively to people experiencing homelessness and prevent individuals from being discharged without the proper support if they are at risk of homelessness or living on the street.

> **"Homelessness is a failure of different systems."**
>
> Julia Wagner, Programme director,
> Institute of Global Homelessness

ADDRESSING THE CHALLENGES

Increase cultural competency: In order to deliver effective and equitable healthcare to diverse populations, healthcare providers must be equipped to address the specific needs and preferences of all of their patients.[94] Cultural awareness and respect can enhance communication between clinicians and providers and lead to improved patient understanding and health outcomes.[95] Cultural competency training is critical in achieving this aim.[94] Yet, less than half of Index countries (43%) provide cultural competency training for healthcare providers. Updating provider training curricula to include cultural competency can help to reduce inequities in healthcare and improve the quality of care for marginalised populations.[95] In addition, countries must prioritise ongoing education in cultural competency to increase awareness and ensure that health systems promote an inclusive environment.[94]

Empower communities: Equipping marginalised communities with knowledge and resources is crucial to improving health outcomes. Initiatives to conduct outreach to these communities about their rights and improve understanding of what constitutes appropriate medical care can be instrumental in dismantling barriers to equal healthcare access and treatment. In addition, empowering the general public to recognise and call-out inequities or injustice through "end discrimination" campaigns and similar programmes can improve societal support for traditionally excluded groups.

Frontrunners in action

Understanding community needs is essential for creating useful and beneficial health services and programmes. When creating new public health programmes, organisations such as PATH, a global body that aims to increase health equity, use a strategy called equity programming, which involves crafting new programmes in consultation with the communities that they will serve. "It's important to understand what the needs are and what is useful to communities," PATH's CEO, Nikolaj Gilbert, tells us. "When you bring the community into the programme design from the outset, you can build respect and create a sense of belonging."

Conclusion: a call to action

A targeted approach that integrates programmes and support systems and is tailored to the unique needs of vulnerable populations, is sensitive to the preferences of individuals and communities and representative of the existing inequalities in health outcomes is the only way to build truly inclusive and holistic health.

Transitioning beyond the design of complex policy to the implementation of targeted programmes, initiatives and support mechanisms is critical for health inclusivity. The Health Inclusivity Index provides insight into the interconnectivity that exists across social, economic, infrastructure and community-level domains of society, and collectively influences the health and wellbeing of populations across the globe. Nations must, therefore, develop policies and complementary implementation mechanisms that address the full spectrum of factors that influence the ability of individuals to reach their optimum state of health.

Implementation must focus not only on the needs of the general population, but also on how to inclusively address the needs of vulnerable and marginalised groups.

A targeted approach that integrates programmes and support systems and is tailored to the unique needs of vulnerable populations, sensitive to the preferences of individuals and communities and representative of the existing inequalities in health outcomes is the only way to build truly inclusive and holistic health. This approach requires countries to work collaboratively across all facets of society, address the social determinants of health, build community-based health systems and support individual health needs.

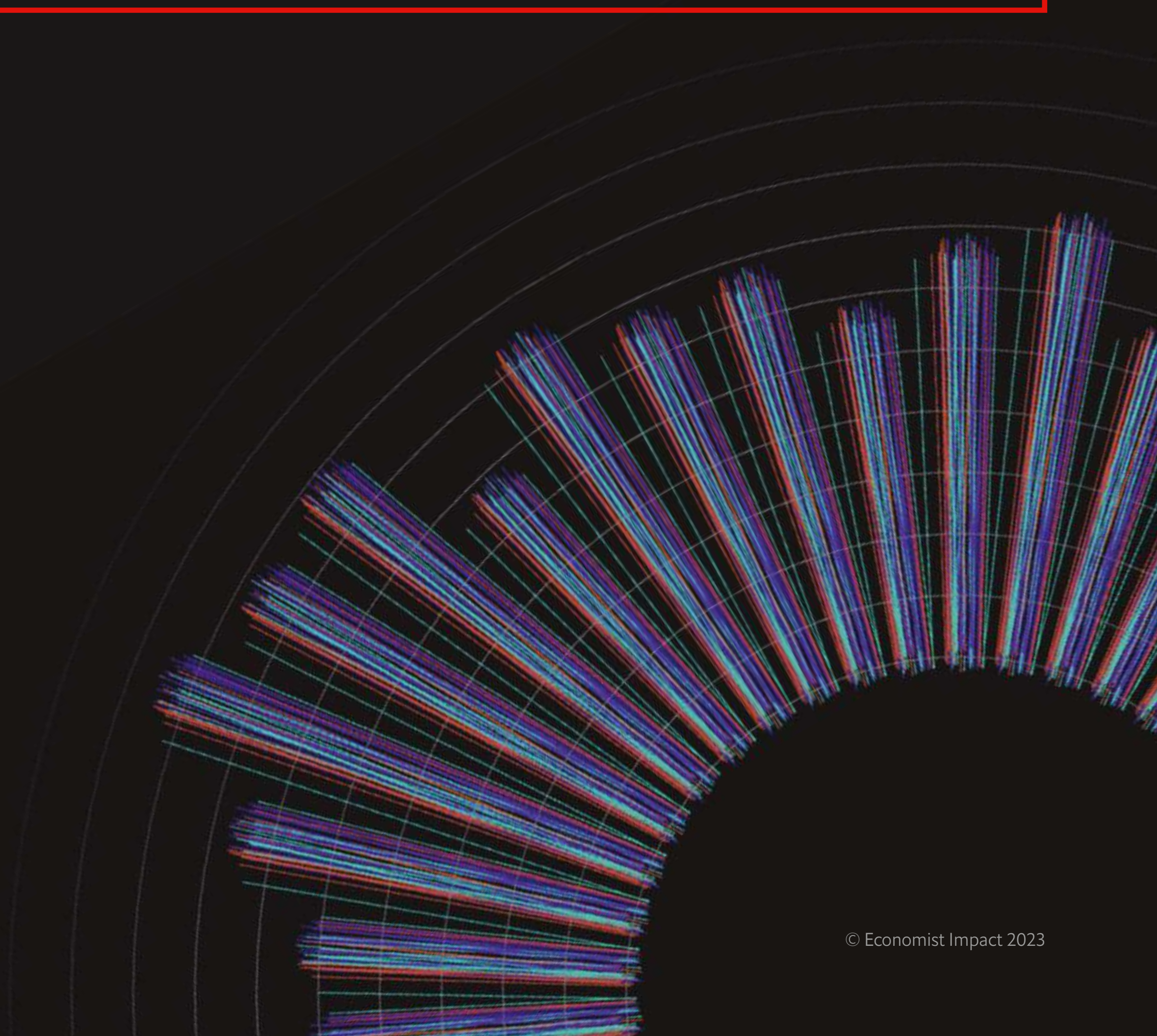
The Health Inclusivity Index provides a tool for stakeholders in countries to understand where they are on the journey towards providing holistic, inclusive health to everyone and what elements they should prioritise to drive the biggest changes.

Figure 28: Addressing the challenges

Key challenge	The rationale	What has already been tried and tested?
Implementing a whole-of-society approach to health	There is a need to create robust implementation plans to solidify whole-of-society approaches. Although policy is an important foundation, it is the operationalisation of whole-of-society approaches that will improve health inclusivity. Policymakers and other stakeholders must work together to establish mechanisms for implementation, particularly for services and populations that are commonly neglected. This starts with defining the roles of stakeholders across sectors in translating policy into action-oriented initiatives. For more information, see our guidance on: (1) Designing policy for implementation; (2) Encouraging multisectoral collaboration	The Lambeth Living Well Collaborative, which serves the South London borough of the same name, includes people who use services, as well as clinicians, carers, secondary mental health services, voluntary sector providers, primary care practices, public health and commissioners to radically improve the way mental health services work.
Reducing cost-related barriers to healthcare, specifically out-of-pocket payments in the health system	Cost remains one of the key barriers to accessing and maintaining good physical and mental health. Out-of-pocket payments made directly by individuals are among the most substancial funding mechanisms in numerous healthcare systems, particularly in developing nations. These payments can worsen inequality and push marginalised communities further into poverty. Countries must leverage innovative strategies to reduce out-of-pocket payments; these should work across the health systems functions framework, including: (1) stewardship; (2) creating resources; (3) health-financing mechanisms; and (4) delivering health services. For more information, see our guidance on: (1) Leveraging digital tools (2) Investing in prevention	In September 2018, the Indian government launched Ayushman Bharat Digital Mission (National Health Protection Scheme). This initiative, among the world's largest government-funded health insurance schemes, strives to offer healthcare coverage to 100mn low-income families in India. The plan is designed to be digital, cashless and paperless, utilising IT platforms and data analytics for treatment preauthorisation and claims processing. This approach ensures the verification of beneficiaries and prevents fraudulent claims.
Ensuring that robust and disaggregated data-collection mechanisms are in place	With limited resources, it is essential to focus efforts on services, issues and subpopulations where the greatest need exists. Globally, national and sub-national data gaps prevent actors from developing informed policies and targeting initiatives effectively. For more information, see our guidance on: (1) It all starts with data	The WHO's Health Inequality Data Repository is an example of recent progress on developing an evidence base of disaggregated data that can be used to create equity-oriented policies.
Establishing formal processes to increase engagement of communities, particularly vulnerable populations, in health policy and programme development	Community engagement in policy, programme development and service design fosters transparency and public accountability. By involving the public, communities can actively contribute to promoting health from the bottom up. We can empower communities by listening to and acting on their views—especially those of members of disadvantaged groups. This approach can drive collaborative design and the implementation of interventions that are more likely to be feasible, accepted and ultimately successful in improving health. For more information, see our guidance on: (1) Engagement of individuals and communities (2) Leveraging community-based mechanisms	Our Views, Our Voices is an initiative that seeks to meaningfully involve people living with non-communicable diseases (NCDs) in the NCD response, supporting and enabling individuals to share their views to drive action and change.
Incorporating mechanisms that address structural and systemic racism and discrimination	Marginalised groups and individuals with chronic health conditions are disproportionately impacted by systemic barriers and continue to experience inequitable health outcomes. Structural discrimination means that certain members of society have limited agency and differential access to basic necessities (eg, education, housing) that are social determinants of health. Such inequities are avoidable and, therefore, require the implementation of bold, yet realistic mechanisms to address them globally. For more information, see our guidance on: (1) Addressing barriers to healthcare access	The New Zealand Government's Māori Health Action Plan 2020-2025 includes The Anti-Racism Kaupapa, which supports the country's health system to better understand, react and respond to racism in health.

> “Some regions of the world are still significantly underserved in terms of the data available, locally relevant data, that can inform action. We need solutions-oriented research to understand what kinds of interventions can really make a difference.”

Dr Jeni Miller,
Executive Director,
The Global Climate
and Health Alliance



Appendix A: Detailed framework

Domain 1: Health in Society				
1.1 Health as a priority				
1.1.1 Right to health	Existence of the right to health principle (or the right to the enjoyment of the highest attainable standard of physical and mental health) in national constitution and/or government strategies	a) Is the country's national health strategy (or other government documents) based on the principle of health as a human right? b) Does the right to health expand beyond access to health care to include safe drinking water and sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality?	Scored 0-2, where 2 = best 2 = There is evidence that the right to health expands beyond access to health care to include safe drinking water and sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality. 1 = There is evidence that the national health strategy (or other government documents) are based on the principle of health as a human right. 0 = There is no evidence that the national health strategy (or other government documents) are based on the principle of health as a human right.	0 - 2
1.1.2 Wellbeing promotion	Existence of the concept of wellbeing in national health strategy/ plan or policies	a) Is the concept of wellbeing included in national health strategy/plan or policies? b) Does wellbeing cover physical and mental health, as well as social wellbeing?	Scored 0-2, where 2 = best 2 = There is evidence that the concept of wellbeing covers physical and mental health, as well as social wellbeing. 1 = There is evidence that the concept of wellbeing is included in national health strategy/plan or policies. 0= There is no evidence that the concept of wellbeing is included in national health strategy/plan or policies.	0 - 2
1.1.3 Social determinants of health in policy	Existence of policies to address the social determinants of health	Does the country have a strategy or specific policies that address the impact of the social determinants of health?	Scored 0-1, where 1 = best 1 = There is evidence of a national strategy or policy that mentions the social determinants of health and includes specific targets and policies. 0 = There is no evidence of a national strategy or policy that mentions the social determinants of health and includes specific targets and policies.	0 - 1

Domain 1: Health in Society

1.1 Health as a priority (continued)

1.1.4 Vulnerable population groups	Existence of policies to identify vulnerable population groups and to reduce health inequalities experienced by these groups	a) Is there evidence of the identification of specific population groups vulnerable to the effects of health inequalities driven by the social determinants of health? (See checklist) b) Does the country have health-related policies for at least 5 vulnerable populations groups? (See checklist) c) Has the country implemented policies to address gender-based violence? *Checklist: women, children and adolescents, persons with disabilities, indigenous peoples, internally displaced populations, ethnic, racial, or religious minorities, migrants, persons living with HIV/AIDs, prisoners, lesbian, gay, bisexual and transgender people, other.*	Scored 0-3, where 3 = best 3 = There is evidence of the existence of policies addressing gender-based violence. 2 = There is evidence of health-related policies for vulnerable population groups. 1 = There is evidence of the identification of vulnerable population groups in the country driven by the social determinants of health. 0 = There is no evidence of the identification or health-related policies for vulnerable populations.	0 - 3
1.1.5 Health exclusion	Existence of policies of health exclusion for vulnerable population groups	Are there any national policies or regulations restricting access to healthcare for vulnerable groups?	Scored 0-1, where 1 = best 1 = There is no evidence of national policies or regulations restricting access to healthcare for vulnerable groups. 0 = There is evidence of national policies or regulations restricting access to healthcare for vulnerable groups.	0 - 1
1.1.6 Health inequalities monitoring system	Existence of a national strategy or policy on health inequalities	a) Is there a national strategy or policy on health inequalities? b) Is there an evaluation plan to assess the impact of policies to address health inequalities? c) Does the country have a dedicated monitoring system for health inequalities? d) Is there a government department or a public health body responsible for identifying and monitoring health inequities in the country?	Scored 0-4, where 4 = best 4 = There is a government department or a public health body responsible for identifying and monitoring health inequities in the country. 3 = There is evidence that the country has a dedicated monitoring system for actions addressing health inequalities 2 = There is an evaluation plan to assess the impact of policies to address health inequalities. 1 = There is evidence of a national strategy or policy on health inequalities. 0 = There is no evidence of a national strategy or policy on health inequalities.	0 - 4
1.1.7 Migrant healthcare coverage	Migrant healthcare coverage and ability to access services	Migrant healthcare coverage and ability to access services score from the Migrant Integration Policy Index (MIPEX) index.	Index 0-100, 100 = best	0 - 100
1.1.8 Public and private sector coordination	Existence of formal partnership or strategy to coordinate service delivery between the public and private sector	Is there a formalised and functional partnership or strategy to coordinate service delivery between the public and private sector?	Scored 0-1, where 1 = best 1 = There is evidence of a strategy or formal partnerships between the public and private sector for coordinated service delivery. 0 = There is no evidence of a strategy or formal partnerships between the public and private sector for coordinated service delivery.	0 - 1

Domain 1: Health in Society

1.2 Health in All Policies

1.2.1 Intersectoral cooperation policy	Evidence of cooperation to facilitate the health in all policies approach across sectors	a) Is there evidence that different government departments/ ministries work together to improve the health and wellbeing of the population and to prevent disease? b) Is there an official oversight or responsible group that facilitates this inter-departmental work?	Scored 0-2, where 2 = best 2 = There is evidence that an official oversight or responsible group facilitates the inter-departmental work. 1 = There is evidence that different government departments/ministries work together to improve the health and wellbeing of the population and to prevent disease. 0 = There is no evidence that different government departments/ministries work together to improve the health and wellbeing of the population and to prevent disease.	0 - 2
1.2.2 Tobacco control	Progress towards tobacco control in the country for the period 2010-2020	How many of the six WHO MPOWER measures have been implemented in the country: - Monitor tobacco use and prevention policies; - Protect people from tobacco smoke; - Offer help to quit tobacco use; - Warn about the dangers of tobacco; - Enforce bans on tobacco advertising, promotion and sponsorship; - Raise taxes on tobacco?	Scored 0-4, where 4 = best 4 = Country has implemented all six measures. 3 = Country has implemented five measures. 2 = Country has implemented three or four measures. 1 = Country has implemented one or two measures. 0 = Country has not implemented any of the six measures.	0 - 4
1.2.3 Marketing of foods to children	Existence of any policies on marketing of foods to children	Has the country adopted any policies on marketing of foods to children?	Scored 0-1, where 1 = best 1 = There is evidence of the adoption of policies on marketing of foods to children. 0 = There is no evidence of the adoption of policies on marketing of foods to children. Binary indicator using existing dataset.	0 - 1
1.2.4 Dietary guidelines for healthy eating in policy	Existence of up-to-date dietary guidelines for healthy eating	Are there dietary guidelines for healthy eating that have been published or updated in the last 10 years?	Scored 0-1, where 1 = best 1 = There is evidence of recently published or updated guidelines for healthy eating. 0 = There is no evidence of recently published or updated guidelines for healthy eating.	0 - 1
1.2.5 National policy on alcohol	Existence of national policy on alcohol	Has the country adopted a written national policy on alcohol that includes an organised set of values, principles and objectives for reducing the burden attributable to alcohol in a population?	Scored 0-1, where 1 = best 1 = There is evidence of the existence of national alcohol policy. 0 = There is no evidence of the existence of national alcohol policy. Binary indicator using existing dataset.	0 - 1
1.2.6 Taxes on alcohol and unhealthy food	Existence of taxes on unhealthy food or drink	Are there taxes on unhealthy food or drink in the country (e.g., sugar tax, alcohol minimum pricing regulations)?	Scored 0-2, where 2 = best (+)1 = There is evidence of taxes on unhealthy foods. (+)1 = There is evidence of taxes on alcohol. 0 = There is no evidence of taxes on unhealthy food and drink.	0 - 2

Domain 1: Health in Society

1.2 Health in All Policies (continued)

1.2.7 Food insecurity policies	Evidence of national strategies or policies to address food insecurity	Are there any national strategies or policies addressing food insecurity (e.g., recommending national nutrition programmes that benefit children and their families, or supplemental nutrition assistance programmes for women, infants and children)?	Scored 0-1, where 1 = best 1 = There is evidence of food insecurity policies. 0 = There is no evidence of food insecurity policies.	0 - 1
1.2.8 Oral health policy	Existence of operational policy/strategy/action plan for oral health	Does the country have an operational policy/strategy/ action plan for oral health?	Scored 0-1, where 1 = best 1 = There is a national operational policy/ strategy/action plan for oral health. 0 = There is no national operational policy/ strategy/action plan for oral health. Binary indicator using existing dataset.	0 - 1

1.3 Health in society: Implementation

1.3.1 Basic living standards	Basic living standards of the country's population	Does the general population have access to basic living standards that support health?	Higher = better % of respondents who have access to all of the following four basic living standards and at least two of the remaining extra living standards Basic: a) Clean drinking water b) Clean toilet facilities c) Consistent power/electricity d) Handwashing facilities with soap and water Extra: a) Closed wastewater or sewage system b) Good quality air (e.g., low pollution) c) Internet d) Green space (e.g., forests, parks, gardens)	%
1.3.2 Access to housing	Accessibility and affordability of housing	Can the general population afford high-quality, safe, and stable housing?	Higher = better Average % of the population that agrees across the following three statements: a) I can afford housing without having to sacrifice other necessities like food and healthcare. b) I can afford quality housing that does not cause harm to my physical or mental health. c) I have access to stable, long-term housing and do not have to move frequently.	%

Domain 1: Health in Society				
1.3 Health in society: Implementation (continued)				
1.3.3 Access to education	Existence of barriers to receiving education	Do children face barriers to accessing education?	Lower = better % of respondents with children whose child/children face at least 1 of the following barriers in accessing education: a) Cost (e.g., tuition fees, exam fees, uniforms) b) Distance to travel to school c) Caregiving responsibilities (e.g., for siblings or family members) d) Work during school hours e) Limited access/support for children with disabilities at school f) Physical or mental-health related issues (e.g., chronic illness or pain) g) Menstruation h) Pregnancy or marriage	%
1.3.4 Climate change and health	Impact of climate change on the population's health and livelihood	Has climate change negatively affected the general population's health and livelihood?	Lower = better Average % of the population that agrees across the following five statements: a) I am not able to keep my home at a comfortable temperature during the hottest and/or coldest times of the year. b) Climate change has reduced the availability of food in my community. c) Climate change has negatively affected my main source of income. d) I am worried about the impacts of climate change on my health. e) Climate change is likely to impact my health for the worse (e.g., injury or illness) in the future.	%
1.3.5 Implementation of dietary guidelines	Awareness of dietary guidelines for healthy eating and regular consumption of fruits and vegetables across the population	Is the general population familiar with the country's official dietary guidelines for healthy eating and does the general population implement these guidelines in their diets regularly?	Higher = better Average % of the population that agrees across the following two statements: a) I am familiar with my country's official dietary guidelines for healthy eating. b) Fruits and vegetables are a part of my diet most days.	%
1.3.6 Level of food security	Level of food security	To what extent can people in the country afford to eat healthy, nutritious and varied food that is easily accessible in their community?	Higher = better Average % of the population that agrees across the following two statements: a) There are programmes in my community that help people access food if they need help (e.g., food pantries, vouchers/coupons, cash transfers). b) A variety of whole foods, including fresh fruits and vegetables, are available in my community. Average % of the population that disagrees across the following statement: c) Within the last year, I have not been able to afford enough food to eat.	%

Domain 2: Inclusive Health Systems

2.1 Health spending and service coverage

2.1.1 Government health expenditure	Share of current health expenditure funded from general government sources, social health insurance and compulsory prepayment	Share of current health expenditures funded from general government sources, social health insurance and compulsory prepayment.	Higher = better % of current health expenditure	%
2.1.2 Population spending more than 10% on health	Share of population for which household health expenditure is greater than 10% of total household expenditure or income	Population with household expenditures on health greater than 10% of total household expenditure or income.	Lower = better % of population with household expenditures on health greater than 10% of total household expenditure or income	%
2.1.3 Impoverishment due to out-of-pocket spending	Increase in poverty gap due to household health expenditures, expressed as a proportion of the $1.90 a-day poverty line	The increase in poverty gap due to household health expenditures corresponds to the increase in the mean shortfall of the total population from the international poverty line attributable to household health expenditures (counting the non-poor as having zero shortfall). The increase in the mean shortfall is expressed as a percentage of the international poverty line.	Lower = better % of international poverty line	%

2.2 Infrastructure and workforce

2.2.1 Physicians	Density of medical doctors (per 10,000 population)	Number of medical doctors (physicians), including generalist and specialist medical practitioners, per 10,000 population.	Higher = better per 10,000 population	Rate
2.2.2 Nursing and midwifery personnel	Density of nursing and midwifery personnel (per 10,000 population)	Number of nursing and midwifery personnel per 10,000 population (including professional nurses, professional midwives, auxiliary nurses, auxiliary midwives, enrolled nurses, enrolled midwives and related occupations such as dental nurses and primary care nurses).	Higher = better Per 10,000 population	Rate
2.2.3 Dentistry personnel	Density of dentistry personnel (per 10,000 population)	Number of dentistry personnel per 10,000 population (including dentists, dental assistants, dental therapists and related occupations).	Higher = better per 10,000 population	Rate
2.2.4 Pharmacists	Density of pharmaceutical personnel (per 10,000 population)	Number of pharmaceutical personnel per 10,000 population (including pharmacists, pharmaceutical assistants, pharmaceutical technicians and related occupations).	Higher = better per 10,000 population	Rate
2.2.5 Healthcare provider training	Existence of training curricula for healthcare providers that include concepts of wellbeing, person-centred care, and cultural competency training	a) Do training curricula for healthcare providers (physicians, nurses, midwives, pharmacists, dentists, allied health professionals) include the concept of wellbeing and/or person-centred care? b) Are there any cultural competency training programmes?	Scored 0-2, where 2 = best 2 = There is evidence of inclusion of cultural competency in training programmes for healthcare providers. 1 = There is evidence of inclusion of the concept of wellbeing or person-centred care in training programmes for healthcare providers. 0 = There is no evidence of inclusion of the concept of wellbeing, person-centred care, or cultural competency in training programmes for healthcare providers.	0 - 2

Domain 2: Inclusive Health Systems

2.2 Infrastructure and workforce (continued)

2.2.6 Electronic health records	Existence of a national electronic health record (EHR) system	Is there a national electronic health record (EHR) system in the country?	Scored 0-2, where 2 = best 2 = There is evidence of an electronic health record system integrated at a national level. 1 = There is evidence of an active electronic health record system in the country. 0 = There is no evidence of an electronic health record system in the country.	0 - 2
2.2.7 Telehealth	Implementation of telehealth	a) Is there a national telehealth policy or strategy in the country? b) Does the strategy or policy include objectives and targets for implementation?	Scored 0-2, where 2 = best 2 = The telehealth policy or strategy includes objectives and targets for implementation or an implementation plan with considerations for inclusive access. 1 = There is evidence of a telehealth policy or strategy in the country. 0 = There is no evidence of a telehealth policy or strategy in the country.	0 - 2

2.3 Inclusive health systems: Implementation

2.3.1 Barriers to accessing healthcare services	Prevalence of different barriers to accessing healthcare services	To what extent does the general population face barriers when trying to access healthcare services?	Lower = better % of respondents who face at least one of the following barriers in accessing healthcare services: a) Inconvenient hours of service b)Travel distance or cost of transportation c) Family or cultural beliefs d) Fear of discrimination e) Lack of trust in healthcare providers and services f) Language barriers g) Lack of documentation/ineligibility (e.g., ID or proof of address) h) Lack of accessibility for people with a disability/disabilities i) Lack of available appointments j) Lack of internet access or digital skills	%
2.3.2 Women's health	Access to essential women's health services	To what extent do women have comprehensive access to essential women's healthcare services? Comprehensive access includes family planning services, healthcare services during and after pregnancy and childbirth, paid parental leave, menstrual care products, and preventative health screenings.	Higher = better Average % of women who have access to the following services: a) Family planning services (e.g., contraception) b) Health services during and after pregnancy c) Health services during and after childbirth d) Paid parental leave e) Menstrual care products f) Preventative health screenings, such as for breast or cervical cancer	%

Domain 2: Inclusive Health Systems

2.3 Inclusive health systems: Implementation (continued)

2.3.3 Denied access to care	Whether a patient has ever been denied access to health services	Are members of the general population ever denied access to healthcare services?	Lower = better % of respondents who ever been denied access to healthcare services	%
2.3.4 Discrimination in quality of care	Whether a patient's personal background or demographic characteristics negatively impacts the quality of care received	To what extent has a patient's personal background or demographic characteristics negatively impacted their quality of care?	Lower = better % of respondents who have ever felt that an aspect of their personal background or demographic characteristic negatively impacted their quality care	%
2.3.5 Access to affordable healthcare	Affordability of healthcare for the general population	Does the cost of healthcare limit the general population's access to healthcare services?	Lower = better Average % of the population that agrees across the following four statements: a) The cost of healthcare has made it harder for me to pay for other basic necessities such as housing or food. b) The cost of seeing a doctor (e.g., fees or co-pays) prevents me from seeking care when I need it. c) I struggle to afford the quality of healthcare services that I need. d) I struggle to afford the medication I need to manage my health conditions.	%
2.3.6 Access to electronic health records	Level of online access to health records	Does the general population have online access to health records?	Higher = better % of respondents who have online access to health records	%
2.3.7 Access to telehealth	Level of access to telehealth services	Does the general population have access to virtual / telehealth services when trying to access a doctor or other healthcare services?	Higher = better % of respondents who have access to virtual / telehealth services	%
2.3.8 Availability of essential healthcare services	Availability of essential healthcare services within communities	To what extent are essential healthcare services available in local communities?	Higher = better % of respondents who have access to at least 8 of the following service types within their communities: a) Emergency health services b) Primary care doctor c) Mental health services d) Dental services e) Eyecare f) Sexual and reproductive health services g) Pharmacies h) Walk-in clinics (no appointment needed) i) Community health workers j) Traditional and alternative medicine	%

Domain 2: Inclusive Health Systems

2.3 Inclusive health systems: Implementation (continued)

2.3.9 Accessibility of essential healthcare services	Accessibility of essential healthcare services within communities	Can the general population access essential healthcare services in a timely manner?	Composite indicator composed of 24-hour and 1-week response times where Higher = better Average % of respondents who can access the following services within 24 hours: a) Emergency health services b) Primary care doctor c) Pharmacies d) Walk-in clinics (no appointment needed) e) Community health workers Average % of respondents who can access the following services within 1 week: a) Mental health services b) Dental services c) Eyecare d) Sexual and reproductive health services e) Traditional and alternative medicine	%

Domain 3: People and Community Empowerment

3.1 Cultures of practice

3.1.1 Person-centred healthcare	Existence of a national policy or strategy for person-centred care	a) Is there a national policy or strategy on person-centred care? b) Is the principle of shared decision making implemented by healthcare providers? c) Are patients' preferences considered by healthcare providers (including cultural preferences)?	Scored 0-3, where 3 = best (+) 1 = There is evidence of shared decision making between healthcare providers and patients. 2 = The person-centred care policy includes guidance for healthcare professionals to consider patients' preferences (including cultural preferences). 1 = There is any evidence of national policy or strategy on person-centred care 0 = There is no evidence of a person-centred care approach.	0 - 3
3.1.2 Translation services	Availability of translation services or patient information materials in multiple languages	a) Are reasonable measures taken to provide translation services for people who need them? b) Are there patient information materials in multiple languages, as well as braille and pictorial?	Scored 0-3, where 3 = best 3 = There is evidence of provision of translation services in healthcare settings. 2 = Patient information is available in other languages in addition to the country's official language(s). 1 = There is evidence of accessible forms of communication e.g., sign language, braille and pictorial. 0 = There is no evidence of provision of translation services or availability of patient information in different languages.	0 - 3

Domain 3: People and Community Empowerment

3.1 Cultures of practice (continued)				
3.1.3 Community companions	Involvement of peer-support or community companions (not just family or formal carers) in health care encounters	Does the health system facilitate the involvement of peer-support or community companions in healthcare encounters (especially for vulnerable groups)?	Scored 0-1, where 1 = best 1 = There is evidence of the involvement of peer-support or community companions in healthcare encounters. 0 = There is no evidence of involvement of peer-support or community companions in healthcare encounters.	0 - 1
3.1.4 Case management	Delivery of healthcare using multidisciplinary teams with the involvement of: a) case managers; b) service navigators	a) Do care delivery models include case managers? b) Are there system navigation services for people who need them?	Scored 0-2, where 2 = best (+) 1 = There is evidence of involvement of service navigators in care delivery. (+) 1 = There is evidence of involvement of case managers in care delivery. 0 = There is no evidence of involvement of case managers or service navigators in care delivery.	0 - 2
3.2 People empowerment				
3.2.1 Health literacy programmes	Availability of health literacy programmes	a) Are health literacy programmes implemented for patients and the general population? b) Are health literacy programmes included in the national education curricula? c) Is there a national action plan or strategy on health literacy programmes?	Scored 0-3, where 3 = better 3 = There is evidence of the availability of health literacy programmes in the national education curricula. 2 = There is evidence of the availability of health literacy programmes for patients and the general population. 1 = There is evidence of a national action plan or strategy on health literacy. 0 = There is no evidence of the availability of health literacy programmes or policy.	0 - 3
3.2.2 Health information for self-care	Availability of health information for self-care	Do patient information materials exist in different formats (print and digital) that support patient self-care?	Scored 0-1, where 1 = best 1 = There is evidence of patient information materials that support patient self-care. 0 = There is no evidence of patient information materials that support patient self-care.	0 - 1
3.2.3 Health outreach programmes	Existence of health outreach programmes for marginalised and vulnerable populations	Are health outreach programmes for vulnerable population groups carried out at primary/community levels of care (community health workers, home health nurses, or volunteers)?	Scored 0-1, where 1 = best 1 = There is evidence of the availability of outreach programmes for vulnerable populations. 0 = There is no evidence of the availability of outreach programmes for vulnerable populations.	0 - 1
3.2.4 Public/community participation in policy	Existence of national strategy or policy for involving local communities and the general public in policy development	Are there any national strategies or policies specifying that local communities are involved in policy development?	Scored 0-2, where 2 = best (+) 1 = There is evidence of specific forums for communities or local citizens to engage in policy development. (+) 1 = National strategy or policies include detailed guidelines on how local communities can get involved in policy development. 0= There is no evidence of national strategies or policies on local community involvement in policy development.	0 - 2

Domain 3: People and Community Empowerment

3.3. People and community empowerment: Implementation

3.3.1 Social cohesion in community	Level of social cohesion and trust at the community level	a) Do people generally feel that they live in safe communities with people they can trust? b) Do people have a voice in their community, especially when it comes to health-related issues?	Higher = better Average % of the population that agrees with the following six statements: a) There are people (e.g., neighbours or friends) that I could ask for help if I needed it. b) I feel safe walking alone at night. c) People with different backgrounds (e.g., ethnicities, religions, genders, sexual orientation) are treated fairly. d) I am able to speak freely and openly about health-related issues that are important to me. e) I trust my community leader(s). f) I have the opportunity to discuss issues that are important to me with my community leader(s).	%
3.3.2 Quality of engagement with healthcare	General population perceptions of their ability to engage in the health system	a) Does the general population feel that discussions and information about their health are kept private? b) Does the general population feel that their health is discussed in a way that they understand? c) Does the general population feel that their appointments are not rushed and that they have time to ask questions? d) Does the general population feel that they have been given information on how to care for their health at home and are able to use this information?	Higher = better Average % of the population that agrees with the following three statements: a) I feel confident that discussions and information about my health are kept private. b) My health is discussed in a way that I understand (e.g., medical terms are explained). c) Appointments do not feel rushed and I have time to ask questions. d) I have been given advice or information on how to care for my health at home and I am able to use the information and advice given to me to manage my own health at home.	%
3.3.3 Unfair treatment in receipt of services	Whether people receive unfair or discriminatory treatment when accessing healthcare services	To what extent does the general population feel they are denied access to healthcare services or that their health conditions are not taken seriously?	Lower = better Average % of the population that agrees with the following two statements: a) My pain or health conditions are not taken seriously. b) I have been denied tests or treatments that I think would be beneficial to my health.	%
3.3.4 Experiences of person-centred healthcare	Implementation of person-centred healthcare principles in practice	To what extent do health professionals take personal preferences into account and do patients feel empowered to make joint health decisions?	Higher = better Average % of the population that agrees across the following two statements: a) My personal preferences (including cultural preferences) are taken into account. b) I feel empowered to make shared/joint health decisions with my doctor or other health professionals.	%
3.3.5 Access to translation services	Level of access to translation and interpretation services	Does the general population have access to translation / interpretation services when trying to access a doctor or other healthcare services?	Higher = better % of respondents who have access to translation / interpretation services	%

Domain 3: People and Community Empowerment

3.3. People and community empowerment: Implementation (continued)

3.3.6 Features to support access to healthcare	Availability of services that facilitate healthcare access	Are there services available in local communities that make it easier for the general population to access a doctor or other healthcare services?	Higher = better Average % of the population that have access to the following four services: a) Home visits or home delivery of medicines b) Flexible appointments / extended hours c) Free transportation services d) Specific members of the community that provide support for patients (not family members or healthcare professionals)	%
3.3.7 Access to health information	Level of access to health information in the population	To what extent does the general population have adequate access to information about important health topics?	Higher = better % of respondents who feel they have adequate access to information about all of the following seven health topics: a) Lifestyle and health (e.g., diet, physical activity) b) Mental health c) Sexual and reproductive health d) Preventative screenings (e.g., cancer screenings) e) Alcohol, tobacco and drug use f) Dental / oral health g) Healthcare services available in your community	%
3.3.8 Sources of health information	Access to trustworthy health information	To what extent does the general population believe that healthcare professionals and national health resources provide trustworthy sources of information about health?	Higher = better % of the population that indicates that at least one of the following provide trustworthy information about health: a) Your doctor b) Pharmacist c) Community health workers d) Other health professional (e.g., dentist) e) Government websites (e.g., Department of Health, local government)	%
3.3.9 Awareness of person-specific health risks	Awareness of person-specific health risks	To what extent health professionals inform patients if they are at a higher risk for certain health conditions because of their background?	Higher = better % of respondents whose doctor or other health professional has ever given them information about health risks specific to their background	%

Appendix B: Methodology

The second phase of the Health Inclusivity Index builds on the phase 1 Index, which was released in 2022. It looks beyond policies designed by countries to drive inclusive health systems to also assess the extent to which these policies are being implemented in practice. To develop the second phase, Economist Impact integrated a digital survey, an in-person survey and in-person focus group discussions into the Index framework and the analysis. We lay out how we built and conducted these additional data gathering exercises below.

Digital survey

There is no comparable country-level data available on availability of, access to and experiences of using health systems and services globally. In the first phase of the Health Inclusivity Index, implementation and population-level experiences were proxied through a set of publicly available outcome metrics, such as the UN Development Programme's Human Development Index. These metrics allowed us to make assumptions around the extent to which the social determinants of health might be impacting health and health inclusivity in a country. However, they did not allow us to pinpoint which services and systems were inclusive or exclusive.

Economist Impact fielded a digital survey to 39,000 adults aged 18 and older in 39 of the 40 countries included in the Index.[XVII] Across the 1,000 people surveyed in each country, gender quotas were assigned to ensure a representative split of male and female respondents, as determined by national demographics. Respondents were asked seven demographic questions and up to 18 content questions, depending on their gender and other demographic characteristics.

The survey was fielded from June to August 2023.

In-person survey

The digital survey allowed us to understand the experiences of a large portion of the population in many of the countries included in the Index—especially high-income and upper-middle-income countries. However, in order for the Index to be truly inclusive and reflective of population-level experiences, it was also important to reach populations who do not have access to the internet and/or experience limited agency. To do this, Economist Impact selected eight geographically and economically diverse countries in which to conduct an in-person survey.[XVIII] Working with a team of local researchers in each country,

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[XVII] It was not possible to field a digital survey in Cuba. Survey data for Cuba was estimated using data from countries with similar economic characteristics.

[XVIII] Brazil, India, Germany, Kenya, Thailand, the United Arab Emirates, the United Kingdom and the United States we fielded the same survey questionnaire (with minor modifications for contextual specificity) used in the digital survey to at least 300 adults aged 18 and older on an in-person basis. The in-person surveys were fielded in select subnational geographies with a higher proportion of people and communities from lower socioeconomic groups (areas of greater deprivation) according to national data. In many cases, this was either a rural location or an inner-city location. Specific details can be found in Figure B1 below. Bespoke sampling approaches were used in each geography.

The in-person surveys were fielded between June and September 2023.

Before conducting in-person surveys in these countries, Economist Impact submitted its proposed approach and our survey questionnaire to HML IRB, an independent ethics review board, for approval of the global study. The board approved the study in June 2023. Additional ethical approval was obtained in Kenya and Brazil. In Kenya, we also obtained ethical approval at national and State levels from the National Commission For Science, Technology and Innovation, and the State Department For Internal Security And National Administration, part of the country's Ministry Of Interior National Administration. Similarly, in Brazil we received institutional and national-level approval from the National Commission of Ethics in Research. Research in Brazil is ongoing.

At the time of the launch of the second phase of the Health Inclusivity Index, in-person surveys have been completed in seven of eight of the countries.

We are grateful for the time and dedication of the research teams that conducted the in-person survey. They are (in alphabetical order by country):

- **Germany:** Kushagra Dixit, Baqir Kar, Zubin Khan, Ayush Jain, Alex Meyer, Ewaz Mur, Kumail Naqvi, Pooja Negi and Prakhar Swapnil
- **India:** Gaurishankar, Ipatsham, Abhay K Jha, Jyoti, Komal, Komal Kureel, Madhu, Swati Mishra, Nidhi and Santanu
- **Thailand:** Nisarat Aunchanthee, Chanikant Boutong, Preecha Butrat, Terdpong Hanchangsit, Surachet Khampan, Bunyaporn Lubthaisong, Teerapat Paokanha, Kritsada Phatchaney, Ariya Promjantuk, Benjathip Putsai, Denpong Sankhum, Orawan Somuangsae, Chaichana Sripierchai, Suchada Sriudon, Pakanan Sutthiprapa
- **UAE:** Yahya Aljalad; Layan Banat; Basim Cheriyapulikkal, MBA; Farah Al-Maayta; Dala Qader Al Majali; Sahla Ullattuparamban
- **US:** Lisa Barr, Shawn Brown, Jesse McKnight and Camille Smith.

Figure B1: Locations for in-person survey research

Country	State/City	Location
Brazil	Pernambuco	Recife (and surrounding areas)
Germany	Frankfurt	Surrounding areas
Kenya	Bomet	Bomet County
India	Delhi	Delhi NCR
Thailand	Khon Kaen	Ban Thum
UAE	Abu Dhabi	Surrounding areas
UK	Kent	Medway
US	Washington DC and Maryland	Wards 5, 7 and 8; Prince George's County

Modelling the survey data for the Index

Inputting the survey data into the Index model necessitates having one number per country for each indicator. To get this data for each survey-based indicator and ensure that it was reflective of the population in each country, Economist Impact used the in-person survey data to adjust the digital survey data for each country.

In countries where we fielded both an in-person survey and a digital survey, we used a weighted average methodology to combine the two datasets. We assigned weights to each survey type based on the population sample surveyed across each to best reflect the country's urban-rural split, digital access levels and education levels. We then incorporated these weighted, combined data into the Index.

In countries where we only fielded a digital survey, we undertook a scaling exercise to estimate in-person survey data in each country. As a first step, we re-weighted the digital survey data to reflect the breakdown of age, gender, rural-urban split, digital access and secondary/tertiary education attainment at the national level. If the re-weighted data reflected the general population (within 5 percentage points of the general population figure) across at least two of the following demographic factors—rural/urban split, digital access and secondary/tertiary education levels—we used the re-weighted survey data in the Index.

If the re-weighted data still did not reflect the country's population demographics, we selected a proxy country (based on GDP, income, population, urban-rural splits, digital access and region) from the seven countries where we fielded an in-person survey. We developed a ratio for each survey question between the digital survey data for the country being scaled and the proxy country's digital survey data. For each survey question, we applied the calculated ratio to the proxy country's in-person survey data. This new dataset was used as our estimated in-person survey data for the country being scaled. We then applied a weighted average approach to combine this estimated in-person survey data and the digital survey data to best reflect the country's demographics. These scaled, re-weighted data were used in the Index.

It is important to note that this modelling approach was only used to transform the country-level data for each survey question. We did not apply this modelling approach to sub-populations in each country. Where sub-population figures are referenced in the report, these figures are based off of the unweighted digital survey data.

Figure B2: Access to translation services in Uganda

36.5% →
Access to translation services
Uganda didgital survey - weighted

1.09 →
Ratio of Uganda digital survey value to Kenya digital survey value of access to translation services

19.5% →
Uganda ESTIMATED in-person survey value = 1.09 x Kenya in-person survey value

26.3%
Final value
Weighted average of Uganda digital survey value estimated in-person survey value

Index modelling

Each survey-based indicator was integrated into the Health Inclusivity Index model, where it was integrated with the policy research conducted in phase 1. We normalised each indicator score and then aggregated the scores across categories and domains to enable comparison across countries. Normalisation rebases the raw indicator data to a common unit so that it can be aggregated. **All indicators in this model are normalised to a scale of 0 to 100, where 100 indicates the optimum score.**

Most indicators are transformed on the basis of a minimum/maximum normalisation, where the minimum and maximum raw data values across the 40 countries are used to bookend the indicator scores. The indicators for which a higher value indicates a more favourable environment have been normalised on the basis of:

$$x = (x - \mathrm{Min}(x)) / (\mathrm{Max}(x) - \mathrm{Min}(x))$$

where Min(x) and Max(x) are, respectively, the lowest and highest values in the 40 countries for any given indicator. The normalised value is then transformed from a 0-1 value to a 0-100 score to make it directly comparable with other indicators. In effect, this means that the country with the highest raw data value will score 100, while the lowest will score 0 for all indicators in the Index.

For the indicators for which a high value indicates an unfavourable environment, the normalisation function takes the form of:

$$x = (x - \mathrm{Max}(x)) / (\mathrm{Min}(x) - \mathrm{Max}(x))$$

where Min(x) and Max(x) are, respectively, the lowest and highest values in the 40 countries for any given indicator. The normalised value is then transformed into a positive number on a scale of 0-100 to make it directly comparable with other indicators.

Index weights

The weights defined by Economist Impact and the Expert Steering Committee are the default setting. They are based on a discussion between Economist Impact and the Expert Steering Committee on the relative value of each category and indicator, which took place in July 2023.

This weighting option uses expert judgement to assign weights to indicators; this brings a real-world perspective to an Index, which is important if an Index is to guide policy actions.

In-person focus group discussions

Although the in-person survey data allowed us to close the digital divide in our survey, our in-person sample sizes were not large enough to explore the experiences of vulnerable populations in depth. To do so, we conducted an in-person focus group with between seven and ten people in the eight countries where we undertook or are undertaking in-person surveys.

Working with our local partners, we selected a vulnerable population to focus on in each country. This selection was primarily informed by a literature review that identified pockets of society in the country that have been historically marginalised and, therefore, face the greatest health challenges. These populations also have some of the poorest health outcomes compared with the wider population.

Focus group discussions were conducted between June and October 2023. In advance of conducting the discussions, Economist Impact submitted our proposed approach and our discussion guide to HML IRB.

Figure B3: Focus group discussions by country: populations of focus

Deep-dive country	Population of focus
Brazil	Low-income migrants from Venezuela
Germany	Ethnic minority groups
India	People living in slums
Kenya	Low-income women
Thailand	Older adults
UAE	Migrant workers
UK	People living with disabilities
USA	LGBTQIA+ community

Interviews with civil society organisations

From August to October 2023, we conducted eight interviews with international civil-society organisations (Figure B4) who support other vulnerable populations and marginalised groups that we were unable to engage directly during the research.

Figure B4: Civil society organisations and the populations they support

Civil society organisation	Population supported
Women's Brain Project (WBP)	Women living with brain diseases
The International Initiative for Mental Health Leadership (IIMHL)	People at experiencing/at risk of mental health and addiction issues
Save the children	Disadvantaged children
Population Action International (PAI)	Women and girls
The Global Climate and Health Alliance	Marginalised groups impacted by climate change
PATH	Global health inequities
Human Rights Watch	Migrants
Institute of Global Homelessness	People experiencing homelessness

Appendix C: Country selection

In phase two of the HII, we analyse 40 countries from across the six WHO regions:

- African Region – Algeria, Kenya, Nigeria, Rwanda, South Africa and Uganda
- Americas Region – Brazil, Canada, Costa Rica, Colombia, Cuba, Honduras, Mexico and United States
- Eastern Mediterranean Region – Egypt, Jordan and United Arab Emirates
- European Region – France, Germany, Israel, Italy, Kazakhstan, Poland, Turkey, Russia, Slovenia, Sweden, Switzerland, Ukraine and the United Kingdom
- South-East Asian Region – Bangladesh, India, Indonesia and Thailand
- Western-Pacific Region – Australia, China, Japan, Philippines, South Korea and Vietnam

Within each region, countries with the largest populations, and a diversity of income levels, were selected. Population and income criteria were established in order to compare countries facing similar organisational challenges due to their size, and also to highlight issues and achievements across income levels. Our country selection does not have the same number of low-, middle- and high-income countries because in certain regions (such as Europe), there are no low-income countries, implying that more middle- and high-income countries would be selected. The final selection includes 15 high-income countries, 11 lower-middle-income countries, 12 upper-middle countries, and two low-income countries.

The Index follows the World Bank's classification of income levels based on gross national income (GNI) per capita. The 40 index countries are classified within the income levels as follows:

- High-income countries – Australia, Canada, France, Germany, Israel, Italy, Japan, Poland, Slovenia, South Korea, Sweden, Switzerland, United Arab Emirates, the United Kingdom and United States
- Upper-middle-income countries – Brazil, China, Colombia, Costa Rica, Cuba, Jordan, Kazakhstan, Mexico, Russia, South Africa, Thailand and Turkey
- Lower-middle-income countries – Algeria, Bangladesh, Egypt, Honduras, India, Indonesia, Kenya, Nigeria, Philippines, Ukraine and Vietnam
- Lower-income – Rwanda and Uganda

In addition to including a regional filter for the data presentation in the workbook, we also provide a filter by income group. The geographical and income-level filters were established in order to compare countries facing similar challenges, as well as to learn best practices from countries at similar levels of development.

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