Bridging the equity gap in maternal and child health

Will depend on health systems research as well as action

We cannot allow it to be said by history that the difference between those who lived and died... was nothing more than poverty, age, or skin colour.

John Lewis, Congressman from Georgia, on the devastation caused by hurricane Katrina.¹

That we live in a world with vastly unequal distribution of wealth and resources was cruelly underscored by the recent disaster in New Orleans, proving that income inequality often translates into huge gaps in access to care and support during crises. In the wealthiest nation of the world, income inequality has been climbing steadily, with more than 50% of income going to the top 20% of households, 37 million people living below the poverty line, and 45.8 million lacking health insurance.² These disparities may be much wider in many developing and middle income countries.

Differences in health status caused by such disparities in wealth are often avoidable and unjust, and inequities in maternal and child health are the starkest examples. Just as many children die in Africa every month, mostly from preventable and easily treatable diseases, as were lost in the Asian tsunami last year. Of the 10 million deaths every year among children aged under 5, more than 40% occur in sub-Saharan Africa, mostly among malnourished children.³ Five countries in South Asia account for almost 38% of the global burden of deaths among newborns,⁴ and most of the 500 000 maternal deaths which occur each year world wide happen in just 13 countries.⁵ In addition to these large differences between countries and regions, some of the greatest inequalities in mortality are seen between the rich and poor within developing countries. As interventions and programmes are implemented, failure to recognise and act on such differentials may actually worsen inequity.⁶

In the words of Stephen Matlin, the executive director of the Global Forum for Health Research, "The great challenge today is to move from describing the problems to acting upon them—and then accurately measuring results."⁷ Several recent reviews suggest that simple, cost effective interventions can prevent many maternal and child deaths,⁸⁻⁹ but the poor populations at greatest need too often lack access to such help.¹⁰

Research has to be relevant, and there are several prerequisites for this. Firstly, the development of large scale, evidence based interventions depends on information derived from sound systematic reviews, which is in turn based on synthesis of appropriate information. Recent attempts at summarising such information on the survival of newborns and children show that much

of the "evidence" is collated only from studies of the efficacy of treatment.⁸⁻⁹ There is too little research on health systems and services, and few effectiveness trials describe what works in sufficiently representative settings.¹¹ Consequently nobody knows how best to develop and implement large scale interventions within health systems, particularly those approaches which promote equitable distribution of benefits to health.

To illustrate, the abysmally short supply of skilled health workers in many parts of the world, such as sub-Saharan Africa, means that health care must be delivered by other types of community workers. Moreover, failure to understand the sociocultural determinants of health and disease may considerably impede health programmes, especially in societies where the health and rights of women and children are closely intertwined. Although these problems are of largely local relevance, they are vitally important and should be investigated. Yet few qualitative studies and systematic reviews on such issues are available. We do not simply need more research; we also need the right kind of research.

Achieving the millennium development goals—international commitments to tackle poverty and hunger, ill health, gender inequality, lack of education, lack of access to clean water, and environmental degradation—will also depend on health systems research and will require huge investments by donors and national governments.¹² The international community was asked 15 years ago to invest at least 2% of national health expenditures and at least 5% of development aid for research and for strengthening the capacity for research,¹³ recommendations that were endorsed at the WHO summit on health research in Mexico in November 2004.¹⁴

Progress since the Mexico summit has been painfully slow. Despite a rousing speech by Bill Gates at the World Health Assembly in May on the importance of strategies to deliver health interventions, the Gates Foundation and other bodies funding research have yet to allocate suitable funding for health systems research. Notably, of the 43 projects funded under the Gates Foundation's Grand Challenges scheme, none relate to operational research and large scale strategies for healthcare delivery and only one focuses on developing tools to measure health outcomes.¹⁵ Furthermore, the first four funding cycles of the Global Fund to Fight

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AIDS, Tuberculosis and Malaria, which provided grants of more than \$850m, (£460m, €685m), did not focus either on assessing the impact of interventions or on a robust programme for health systems research.¹⁴ If the global agenda to reduce the burden of disease among poor children is to progress, evidence based interventions must be accompanied by meticulous documentation of impact and a clear process for learning.

This week has witnessed one of the largest assemblies of public health workers and partners at the ninth meeting of the Global Forum for Health Research in Mumbai, as well as the launch at the UN Summit in New York of the new global Partnership for Maternal, Newborn and Child Health. Both of these well intentioned events underscore the need to reduce the inequity in global child health through concerted action and appropriate research. It is now time to translate rhetoric into action.

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Evidence based reform of mental health care

Early, intensive, and home based treatments are the answer

Two big ideas have dominated reform in mental health care in recent years and underpin the widespread enhancement of services that is being attempted in England. These are that people with mental disorders should have treatment in the community, and that young people with early psychosis should receive timely and comprehensive intervention during the critical years following onset. Two large, high quality studies in this issue report much needed evidence on the impact and feasibility of these drivers for reform.^{1 2} Both studies are large and well designed and report positive results in support of the present reforms.

Johnson and colleagues (p 599) show elegantly that providing, in a disadvantaged inner city community, intensive treatment at home for acutely ill people with severe mental disorder substantially reduces the use of inpatient care.¹ The number needed to treat attests to the potency of this effect, which seems to be sustained for at least six months. Furthermore, although treatment at home did not increase risk, patients were less exposed to the disruption and the often harmful effects of inpatient care. This study also indicates that home treatment could be highly cost effective.

Petersen and colleagues (p 602) show that more intensive, assertive community treatment in early psychosis produces better outcomes at two years than does standard care,² reinforcing the message from a similar UK trial.³ Similarly, the OPUS study assessed intensive care during the critical period in early psychosis,⁴ but the content in the Petersen trial was less specific for that phase of illness than in the intervention used in other programmes for treating early psychosis.⁵ More phase specific forms of psychosocial intervention,⁶ preventive programmes to help

people back to work,⁷ and earlier detection of psychosis⁸ may further improve outcomes.

These two concepts of reform are related but have evolved sequentially. The model of community psychiatry was spawned within the wider process of deinstitutionalisation and was ignited sociologically, not scientifically. Science came later. And where the community model has struggled, it has been for economic rather than scientific reasons. The reforms towards early intervention in psychosis, catalysed by the rise of community psychiatry, have developed along with evidence based medicine, which emerged at the same time. Representing the overdue introduction of early diagnosis into psychiatry, this process has woven science, clinical care, consumerism, values, and sociology into a potent blend. This disturbs some people, who defend treatment as usual.⁹ Are they defending the indefensible?

The criticism that each reform process has attracted deserves deeper analysis. Both reform and resistance to it are complex phenomena influenced by values, evidence, and opinion. The resistance to early intervention in psychosis is based on an overly narrow interpretation of the evidence based model.¹⁰ Evidence based medicine refers to individual interventions and diagnoses while evidence based health care focuses on systems and models of care.¹¹ Evidence based practice is an even more pragmatic and mature concept which integrates the best research evidence with clinical expertise and patients' values. Studies of new approaches to evidence based practice are difficult to carry out, and high quality studies, such as the two in this issue are rare.^{1 2}

Critics argue that reforms to health care should not begin until the evidence base for them is virtually complete. Yet we cannot remain paralysed, waiting for

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