

Building Equitable Healthcare Institutions in Low- and Middle-Income Countries: Lessons from Wealthy Nations

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ABSTRACT

Healthcare disparity continues to serve as serious obstacle in addressing health needs among disadvantaged populations across the globe. The member states of the Organization of Economic Co-operation and Development (OECD) have attained universal health coverage (UHC) for the past decades, and therefore, there are lessons Low- and Middle-Income Countries (LMICs) can learn from them and contextualize to their settings to strengthen their health systems and minimize healthcare disparities. We reviewed the health system strengthening (HSS) journey of the OECD member states, identified, discussed, and provided recommendations on key HSS pillars that can be adapted by the ten poorest countries to accelerate their health system strengthening efforts toward minimizing healthcare disparities and improving the quality of life for their citizens. The HSS pillars are expansion in healthcare access, improved healthcare spending, demand for more responsive healthcare, cross country study and experience sharing, and prevention policies to promote better health. In the report we also discussed the interwoven relationship between suboptimal governance, pervasive poverty, and fragile health systems in LMICs and suggested how addressing them will pave way to bridging health disparity in LMICs. The strategies and recommendations discussed in the review are critical to enacting good governance, strengthening health systems, and bridging healthcare disparities in LMICs. Strong political will and commitments by the governments of the LMICs, effective, transparent, and accountable partnership with OECD serve as the prerequisites for the strategies and recommendations provided in this report to yield desired impact.

INTRODUCTION

Globally, there is an increased rate of inequalities not only in low- and middle-income (LMIC) countries but even in developed and economically viable nations due to the escalation of economic and social imbalances [1] with potential public health catastrophes as observed during the recent COVID-19 pandemic. This healthcare crisis resulted in the disruption of routine healthcare delivery services including the supply chain of essential medicines and equipment, overstretched healthcare workforce and their psychological and mental health, among others. Health disparity or inequity refers to gaps in the quality of and delivery of health across racial, ethnic, gender and socioeconomic groups and these disparities occur in most countries across the globe with different intensity [2]. Variations associated with race, socio-economic and social imbalances among nations and within countries continue to pose significant obstacles to building equitable institutions [3]. The concentration of wealth and resources in the hands of a few can undermine efforts to establish fair and accountable governance systems. Good governance, adequate transparency and accountability are critical for ensuring that resource wealth is managed for the benefit of the whole population [4]. Transparency and accountability in governance promotes trust in governing officials thereby strengthening institutions and making them be more accountable.

Corruption remains a pervasive problem in many parts of the world and in 2018 statistics revealed at least \$2.6 trillion was spent on bribes, kickbacks and other unethical transactions, equivalent to 5% of global gross domestic product [5]. Corruption increases the cost of health care and education services, thereby lowering their quality and accessibility; it weakens institutions, erodes public trust, and hinders the equitable distribution of resources and services, while its absence results in better health and education outcomes [6]. Fighting corruption and establishing transparent systems is crucial for building accountable institutions [7]. In developing countries where in some cases poor governance fuels corruption, an inadequate rule of law can lead to impunity for those in power, fostering a climate of injustice and undermining public confidence in institutions. Therefore, in developing countries, strengthening the rule of law and legal institutions such as strong, accountable, and independent judicial systems, rigorous and impartial public administration, and transparent laws with predictable enforcement are critical toward strengthening other public institutions [8].

The lack of effective equitably accountable institutions deprives people of education, employment and income which have a marked influence on the health of a population. In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socio-economic position, the higher their risk of poor health [9]. Health institutions, such as healthcare systems, hospitals, clinics, and public health agencies, face various challenges in building effective, equitable, and accountable structures. Similarly, factors contributing to health inequalities significantly vary between countries and are linked to many factors, including differences in exposure to health risk factors and in access to healthcare. Recently, health disparity mapping conducted in eleven high-income countries revealed that the United States leads in terms of geographical health disparity with majority of rural dwellers reporting skipping healthcare interventions due to lack of access [10]. Generally, the people in poor countries tend to have less access to healthcare compared to those in high-income countries and despite effective strategies that could improve health in these countries, the governments rarely focus on the poor in their policies or the

implementation or monitoring of health service strategies [11]. While high-income countries continue to experience gaps in healthcare, these countries have successfully dealt with many challenges that persist and prevent equitable and accountable healthcare systems in the LMICs. Through a health equity lens, we provide recommendations to improve access to care and improve the quality of health of people in LMICs.

Therefore, the purpose of this review is to identify key challenges that contribute to health disparities in LMICs and to develop recommendations by contextualizing some of the strategies used in some selected high-income countries to bridge the health inequality in the LMICs thereby improving healthcare access and service quality.

Rational and Approach for the Review

The pattern of health disparity varies between wealthiest nations and LMICs. For example, racial health disparity is still highly prevalent in the United States despite the many strides that have been made to improve healthcare [12]. On the other hand, most African countries are disproportionately affected by infectious diseases such as HIV, Tuberculosis, Malaria among others. Additionally, within many African nations, women are disproportionately affected by lack of access to quality sexual and reproductive health and rights thereby making these countries to have the highest maternal mortality rates in the world [13]. Based on several socio-economic indicators, member countries of the Organization for Economic Cooperation and Development (OECD) serve as the wealthiest nations in the world and have the healthiest population [14]. The OECD member states such as Finland, Canada, France, Germany, UK among others have attained universal health coverage decades ago due to strong public health policies and institutions because of political will and good governance. Therefore, this article will review the health systems of the OECD member states, identify best practices, and suggest how they can be adapted to the context of some selected LMICs. Equatorial Guinea, South Sudan, Madagascar, Guinea Bissau, Eritrea, Burundi, Democratic Republic of Congo, Central African Republic, Guatemala and Eswatini are ranked as the poorest nations in the world [15]. The income per Capita of most of these countries when compared to the wealthy OECD nations is about 40 times less [16]. Poverty in most of these countries is precipitated by persistent civil unrests, wars, corruptions, and poor governance. The two sets of countries (OECDs versus LMICs) are incomparable in all parameters, therefore in this article the authors will try to contextualize the best practices from the OECD nations to suit the realities and contexts of the selected LMICs keeping in mind their socioeconomic wellbeing and viability.

DISCUSSION

Several strategies have been deployed by the OECD countries toward promoting better health and narrowing healthcare disparities, however in this article we will review basic strategies that can be adapted to the context of LMICs. Specifically, we will review the following strategies: expansion in healthcare access, improved healthcare spending, demand for more responsive healthcare, cross country study and experience sharing, and prevention policies to promote better health.

Expanding Access to Healthcare

Lack of access to healthcare service is one of the critical barriers toward minimizing healthcare disparity. Ill-health is a cause and a consequence of poverty: sick people are more likely to become poor, and the poor are more vulnerable to disease and disability, while good health is

central to creating and sustaining the capabilities that poor people need to escape from poverty [17]. Healthcare access indicates the affordability, accessibility, availability, and acceptability of services to achieve the best health outcomes [18]. According to World Health Organization (WHO), about half of the global population lack access to basic healthcare [19]. In 2023, Singapore is ranked as the best country with health index score of about 86.9% which is a measure of how healthy the population is, their access to health and health outcomes followed by Japan and South Korea with scores of 86.5% and 84.8% respectively while Central Africa Republic, South Sudan and Chad ranked as the worst with scores of 32.0%, 37.5% and 39.2% respectively [20].

The OECD countries took stepwise approaches toward improving access to healthcare. In the initial stage they defined what should constitute essential care, made insurance coverage of essential care universal and later eliminated financial barriers, ensured adequate supply, and addressed disparities related to social characteristics. Most of the OECD countries attained different levels of insurance coverage by 1990 ranging from insurance that exclude some services or involving cost sharing to insurance that provide full financial protection for all required healthcare services [21]. Health insurance is still suboptimal in many LMIC especially in Africa where only about 17% of people are insured and in some of the poorest nations such as Niger the insurance coverage is as low as 1% [22]. Constraints such as poverty, lack of government support and limited private sector involvement have been identified as the root causes of low insurance coverage in LMICs [23]. Poverty is the major constraints among the three factors and on the other hand government support may serve as a key solution to both poverty and private insurance uptake in LMICs. Private sector involvement in health insurance may not be viable and sustainable in impoverished population, therefore investing in the population to alleviate poverty is likely to be the primary strategy that LMICs should address in the initial stage.

According to the OECD countries, a successful strategy of poverty reduction must have at its core measures to promote rapid and sustained economic growth. Studies have shown that an average increase in a country's growth by 10% will reduce poverty rate by about 10 – 20% [24]. Therefore, by focusing on economic growth of up to 10%, we estimated up to about 25 million people among the ten poorest countries referenced in this article may be pulled out of poverty as illustrated in Table 1. These individuals would have the opportunity to access healthcare through social insurance stream. The more people that are pulled out of poverty and have access to healthcare through social insurance, the stronger and more productive would be the insurance system and the vicious cycle of economic growth – improved healthcare access – effective insurance system will continue to thrive. On the other hand, healthcare centers can complement the efforts of government in facilitating healthcare accessibility by deploying an inpatient-outpatient transformation strategy [25]. This strategy entails aligning services offered by hospitals and other healthcare centers with those needed by their communities by reducing inpatient capacity to a level that closely reflects the communities' needs for acute inpatient beds, shifting resources to enhance outpatient and primary care services offered to the community as needed and continuing with provision of emergency services.

Table 1: Population estimates to be pulled out of poverty following 10% economic growth among top ten poorest nations.

Country	Based on Available Sources		Based on Extrapolation		
	Poverty Rate (%) *	Population Estimate**	Population of the Poor (Poverty Rate applied to Population)	Population of the Poor (10% Economic Growth, Reduced Poverty Rate by 20%)	Population to be out of Poverty
Equatorial Guinea	76.8	1,714,671	1,316,867	1,053,494	263,373
South Sudan	76.4	11,088,796	8,471,840	6,777,472	1,694,368
Madagascar	70.7	30,325,732	21,440,293	17,152,234	4,288,059
Guinea- Bissau	69.3	2,150,842	1,490,534	1,192,427	298,107
Eritrea	69.0	3,748,901	2,586,742	2,069,393	517,348
Burundi	64.9	13,238,559	8,591,825	6,873,460	1,718,365
Democratic Republic of Congo	63.9	102,262,808	65,345,934	52,276,747	13,069,187
Central African Republic	62.0	5,742,315	3,560,235	2,848,188	712,047
Guatemala	59.3	18,092,026	10,728,571	8,582,857	2,145,714
Eswatini	58.9	1,210,882	713,209	570,568	142,642
Total		189,575,532	124,246,051	99,396,840	24,849,210
* https://wisevoter.com/country-rankings/poverty-rate-by-country/#tracker_introduction					
** https://www.worldometers.info/world-population/population-by-country/					

Improved Healthcare Financing

The OECD countries fund healthcare through a government financing scheme, compulsory health insurance either through public or private entities, out-of-pocket payment and voluntary health insurance. These models vary between member counties. The predominant financing mechanisms are compulsory health insurance and government financing scheme while out of pocket is the least used component [26]. On the other hand, the popular health financing mechanism among the LIC is out of pocket payment followed by government spending or external aid as illustrated in Table 2.

In the scenario where the gap between out-of-pocket spending and government spending is very wide as obtainable in Equatorial Guinea or Democratic Republic of Congo, the quality of service provided in government institutions is grossly suboptimal [27] forcing a wealthy population to patronize medical tourism to access quality care. Medical tourism refers to the phenomenon of people traveling outside their home country primarily for the purpose of seeking medical treatment. This condition propagates healthcare disparity since so many resources are spent on healthcare outside the health-tourists' country. This phenomenon results in reduced healthcare spending and deprives the country the opportunity to strengthen the health system which in turn deprive the poor of quality healthcare. This vicious cycle of "healthcare disparity" will continue to put LMICs at a disadvantage while the rich countries such as the OECD member states will continue to benefit from this phenomenon. While it may be argued that rich countries do provide financial aids to the poor nations, however according to

some school of thoughts and experienced economists an influx of foreign aid to LMICs did not seem to produce economic growth but rather, lots of foreign aids flowing into a country tended to be correlated with lower economic growth. The economists justified the allegation that governments of these countries do not care to strengthen tax collection initiatives from citizens since there are “low hanging” resources (foreign aid) and on the other hand the citizens do not hold the government accountable since they too do not pay tax [28]. As illustrated in Table 2, foreign aid has consistently been provided for the past two decades and remains the second highest source of healthcare spending among most of the poorest countries and still the countries lack systems that will ensure economic growth, accessible quality healthcare and appreciable reduction in healthcare disparities. Therefore, OECD nations and other wealthier countries should consider repurposing financial aids to focus on systems strengthening, improvement in economic growth in recipient countries to promote good governance and sustainable economic growth.

Table 2: Trends in Major Healthcare Spending Streams among Ten Low Income Countries (2005 – 2021)

Country	Government Spending (%CHE)				Out of Pocket Spending (%CHE)				External Aid (%CHE)			
Year	2005	2010	2015	2021	2005	2010	2015	2021	2005	2010	2015	2021
Equatorial Guinea	15.9	28.0	23.7	19.9	74.1	62.1	71.5	77.5	3.6	4.9	1.6	0.4
South Sudan				15.9				29.4				49.4
Madagascar	37.1	39.8	39.8	21.0	33.0	36.2	25.2	32.7	23.3	15.8	28.2	40.5
Guinea- Bissau	11.2	8.9	6.6	13.8	52.8	44.4	66.9	60.0	29.8	41.5	23.5	23.2
Eritrea	12.4	21.2	16.6	21.2	35.2	48.5	42.1	49.5	52.3	30.3	41.3	33.1
Burundi	27.3	17.6	38.5	24.5	39.2	28.2	31.2	25.4	31.7	53.0	28.0	56.6
Democratic Republic of Congo	5.2	10.3	16.7	16.8	69.4	37.1	37.4	39.1	18.7	44.8	39.3	37.5
Central African Republic	23.7	16.2	9.1	13.9	53.2	59.5	48.8	49.0	21.9	22.9	41.4	35.9
Guatemala	30.6	33.7	37.9	33.8	62.5	58.9	55.7	61.0	2.3	2.7	1.7	2.3
Eswatini	49.4	49.2	41.8	53.1	13.2	10.5	10.6	10.4	18.8	25.6	32.7	24.2
CCH: Cumulative Health Expenditure												
Source: https://apps.who.int/nha/database/country_profile/Index/en												

Economic growth may have enormous impact towards improving healthcare access. However, economic growth and increased healthcare spending alone are not enough to scale-up healthcare coverage and achieve better health outcomes. These must be combined with accountability of results, transparent management of public funds, and multisectoral efforts with community involvement at the implementation level.

Demand for More Responsive Healthcare

A health system is responsive when it can easily adapt to situations and the needs of its consumers. Health systems can become more responsive by deploying a system thinking approach and ensuring interdependence between health professions education programs, health systems, and the communities they serve. Additionally, a responsive health system should provide inclusive, legitimate, participatory and accountable services, ensure the social rights of citizens, and draw attention to the needs of marginalized and vulnerable groups [29]. A responsive health system will certainly promote equity in healthcare provision since it may accommodate and where possible address healthcare needs of various classes of its consumers. The OECD nations use patient-reported experience measure (PREMs) to continuously improve quality of healthcare and to strengthen health system responsiveness to patients' needs thereby

minimizing healthcare disparity [30]. This strategy can be adapted by LMICs keeping in mind the literacy and awareness level of the population. However, consumers would be able to demand for responsive healthcare only when they are informed, empowered, and are socially included in aspects of healthcare affairs. Social exclusion refers to a state in which individuals are unable to participate fully in economic, social, political, and cultural life, as well as the process leading to and sustaining such a state [31]. Lack of social inclusion of major healthcare consumers such as the poor and underserved population serves as major obstacle toward making health systems in LMICs responsive since majority of healthcare consumers in these settings are the poor. When poor and underserved population are socially excluded, they lack not only access to healthcare but to other health determining factors such as nutrition, shelter, education, employment, humane treatment and more importantly they lack motivation to demand for better healthcare. Therefore, for the LMICs to adapt PREMs model, they need to establish structures using strategies that will effectively promote social inclusion and to create awareness among key stakeholders about responsive healthcare [32].

The first strategy is to involve the excluded people themselves in changing their situation. As early as 2002, an IMF study found that the participation of people with low incomes in the decisions that influence the allocation of public resources would mitigate corruption possibilities and limit the monopoly of power exercised by government officials [6]. Civil society organizations representing various excluded populations should be allowed to represent their respective populations in a forum that will aid dialogue with the government. The government should be as transparent as possible and allow frank and sincere discussions about the challenges that the CSOs will put forward. This is a strong and fundamental strategy that will pave the way for other strategies to be effective. Additionally, CSOs are strong tools that could checkmate corruption and injustice as seen in several African nations [33]. The ability of CSOs to challenge corrupt governments and to demand for justice and inclusiveness has made many corrupt governments in Africa to perceive CSOs as rivals. Some strategies that CSOs can use to facilitate inclusion of their communities include training of local community influencers to boost their confidence and esteem, basic socio-legal and human rights need and empowering communities to take part in participatory local policy decisions making, monitoring and evaluation of healthcare services, education, and other social services.

The second strategy should be aimed at strengthening the capacity of CSOs so that they can exercise their roles freely and autonomously. The OECD and other donors should continue to engage and dialog with governments of LMICs for them to consider CSOs as platforms that could serve as a bridge between them and communities for greater inclusions and good governance. The OECD and other donors can achieve these goals by ensuring that the programs they implement in LMICs take account of inclusion, create awareness of the principal form of exclusion and the policies which contribute or discourage social inclusion and by spreading good practices across countries and regions. Government policies may promote social exclusion or discourage it in several ways and some examples that have proven to be effective are as follows: create legal, regulatory and policy frameworks that promote social inclusion, ensuring that socially marginalized or excluded populations benefit from public expenditure as much as other groups, improving economic opportunities and access to quality health services, education and other related services and by promoting political participation equally by all communities [34].

Sharing Experience and Data for Decisions Making

Historically, most countries that excel economically and have a satisfactory standard of living didn't succeed in isolation but in collaboration with other countries either based on region or socioeconomic interests. For example, the OECD was founded with the goal of promoting the economic welfare of its members. Member countries work together to identify common challenges, develop standards, share experiences, and best practices to solve them [35]. Currently, the OECD nations can boast of average health expenditure as percentage of GDP of 9.2% with countries such as South Africa, Latvia, Chile having 8.5%, 8.8% and 9.1% respectively while other non-members with potential big economies such as China and India hover at 5.7% and 3.0% respectively [36]. This trend serves as example of how organizations can positively influence policies of member countries thereby improving the wellbeing of their populations. The path to the progress by OECD member countries wasn't an easy one and requires full commitment and political will by member nations. The OECD organizational structure is made up of council that provides oversight and strategic direction and takes decisions by consensus, committees and groups that develop standards and innovate and review policies and the secretariat that collect data, provides analysis, and formulate proposals to inform committees discussions and decisions. OECD's decisions are data driven and therefore the organization ensures robust systems for quality data collection. Evidence that are data driven are likely to succeed when implemented. The OECD is one of the world's largest and most reliable sources of comparable statistical, economic, and social data [35].

Of the top ten poorest nations in the world, nine are from Africa (four in East Africa, three in Central Africa, and one each in West Africa and Southern Africa). Over the years there have been a proliferation of African regional organizations with overlapping objectives and in most cases the Africa's leaders are focusing on the wrong set of priorities with too little genuine commitment towards the goal of Africa's development [37]. The proliferation indicates a lack of clear perspective within Africa and the role of external donors that fund African regional organizations, or projects under African regional organizations' aegis without making efforts to harmonize objectives and ensure synergy and efficiency [38]. Lessons from OECD indicate that shared objectives, purpose, and similar challenges may be more relevant when forming organization than regional affiliation. Therefore, the interests of ten LMICs could be better served by putting aside their regional affiliation interests and focus on their shared challenges of healthcare access and disparity exacerbated by pervasive poverty, develop strategic plan with realistic indicators and feasible timelines.

Prevention Policies to Promote Better Health

In settings of limited resources and poverty, prevention policies provide a practical means to achieve better health outcomes at the same cost [39]. To achieve this a careful analysis to identify evidence-based opportunities for more efficient delivery of health care whether prevention or treatment should be conducted and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions [39]. Preventive healthcare policy generally falls into five general categories: immunization, screening, education, counselling, and rehabilitation [40], and has at least three main functions: 1) reducing the cost of illness; 2) easing the strain on medical infrastructure; and 3) optimizing the efficiency of labor resources, as doctors can concentrate on more serious issues. Theoretically, three stages of prevention can be identified: 1) Primary prevention focuses on averting harm before it occurs, typically targeting entire populations and systems; 2) Secondary

prevention involves mitigating the effects of harm that has already occurred; and 3) Tertiary prevention focuses on coping with ramifications of harm and preventing further deterioration [41]. Economically, this saves budgetary funds and mitigates the shortage of medical personnel and infrastructure, thereby promoting better healthcare. However, when implementing this policy, it is important to calculate the cost of the illness and cost-effectiveness, as in some instances, expenses, on the contrary, may be increased. For example, screening costs will exceed the savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures. Whether any preventive measure saves money or is a reasonable investment despite adding to costs depends entirely on the particular intervention and the specific population in question. Hence, proportional, and careful development of tailored preventive measures for each specific issue or disease is advisable. Moreover, it's crucial to consider advancements in treatment technology during the policy's development, as it has been found that high-tech treatments for existing conditions, although, can be expensive, such measures may, in certain circumstances, also represent an efficient use of resources and prevention [39]. Following the implementation of preventive measures, it's essential to regularly audit their cost-effectiveness rather than a cost-benefit analysis to mitigate potential negative consequences in the initial stages or change the strategy [42].

Primary health care improves the performance of health systems by lowering overall health care expenditure while improving population health and access. This corroborates with the quote *"an ounce of prevention is worth a pound of cure – Benjamin Franklin"*. Preventive health has major economic benefits, such as improvement in GDP, reduced environmental impacts and healthcare system cost savings [43]. Prevention and public health policies are a key pillar of any modern health system, and their importance is likely to grow in ageing societies with an increasing number of people living with one or more chronic non-communicable diseases. The consequence of effective preventive health measures and quality healthcare service is longer life expectancies and increase in the population aged 65 years and over. This population is estimated to rise from 16.6% in 2015 to 27.5% by 2050 on average across the OECD [44].

The World Health Organization has identified primary healthcare as the most inclusive, equitable, cost-effective, and efficient approach to enhance people's physical and mental health, as well as social well-being [45]. Considering the LMICs' socioeconomic situation, huge OOP spending, inadequate healthcare infrastructure and resources as well as poor healthcare access and healthcare disparities, it would be wise and cost-effective to invest heavily in primary prevention. This approach if successfully implemented will reduce pressure on the limited health infrastructure since less people will likely become sick and seek intervention in healthcare facilities. When the population of individuals seeking care is reduced, there is likelihood that quality of care will improve since the limited resources at the disposal of healthcare providers are less likely to be overstretched.

For primary prevention to yield the desired results in LMICs settings health promotion should be strengthened and should target behavioral risk factors, nutrition and sexual health including family planning. Through these interventions people would be empowered to take control over their health. A Two-stage approach to health promotion can be deployed to ensure effectiveness and synergy. Structural health promotion approach should be prioritized in the initial stage to target health conditions that are more prevalent among the poor and other disadvantaged

groups. The western world used a structural approach to reduce health disparity between the rich and the poor by taking into consideration the unique needs of the poor when designing health-inequality reduction programs [46]. After adequate and successful reorientation and attainment of behavioral change among the disadvantaged populations, agentic health promotion approach can be introduced in the second stage and people can voluntarily comply to specific interventions targeting particular risky behaviors. Generally, when deploying prevention policies to promote better health, the LMICs should remember that the actual determinants of health inequalities are not limited within the health sector, but rather are grounded within wider social problems as earlier discussed in previous sections of this article. Table 3 summarizes the five HSS pillars discussed in this article, the strategies used by OECD member states to strengthen each pillar and our recommendations for LMICs based on the lessons learned.

Table 3: Summary of Lessons learned from OECD Member States and Recommendations to LMICs

Health System Strengthening Pillars	Strategies Used by OECD Member States	Recommendation for LMICs
Expansion in healthcare access	Made insurance coverage of essential care universal. Eliminated financial barriers. Addressed disparities related to social characteristics	Reduce poverty. Increase government support. Increase private sector involvement. Increasing economic growth by at least 10%
Improved healthcare spending	Effective government healthcare financing scheme with adequate funding. Compulsory health insurance	Minimize out-of-pocket payment of healthcare. Device sustainable healthcare financing and reduce relaying on external aids. Partner with OECD nations to repurpose external aids toward good governance and economic growth.
Demand for more responsive healthcare	Implemented patient-reported experience measure (PREMs) to improve quality of healthcare. Strengthened health system responsiveness to patients' needs. Reduced healthcare disparity	Improve social inclusion of disadvantage population. Empowering civil society organizations to represent their communities and be part of government decision makings.
Cross country study and experience sharing	Formation of OECD based on shared interests rather than on regional affiliation. Data-driven decisions through consensus by OECD member states	Put aside regional affiliation interests when forming organizations. Focus on shared challenges of healthcare access and disparity. Develop strategic plan with realistic indicators and feasible timelines.
Prevention policies to promote better health	Implemented effective preventive health measures. Ensured quality healthcare services.	Invest immensely in primary prevention and health promotion. Focus on structural health promotion first followed by agentic health promotion.

CONCLUSION

This review buttresses the interwoven relationship between suboptimal governance, pervasive poverty and fragile health systems in LMICs. Addressing these three closely related challenges will pave way to bridging health disparity in LMICs. The strategies and recommendations discussed in the review are critical to enacting good governance, strengthening health systems and to bridging the huge healthcare disparities in LMICs. Strong political will and commitments by the governments of the LMICs and effective, transparent, and accountable partnership with OECD serve as the prerequisites for the strategies and recommendations to yield the desired impact.

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