

not available for a huge number of women in China, particularly in the Tibetan Plateau. Xizang had the largest urban–rural disparity in the number of physicians per 1000 people, with 2.11 physicians in rural areas compared with 7.14 in urban areas.³ The coverage rate of HPV vaccination for girls aged 9–14 years is less than 4.0% and screening for women aged 35–64 years in western China is less than 31.3%.^{4,5} Eliminating cervical cancer remains challenging in low-resource settings, particularly in the Tibetan Plateau.

Simultaneous implementation of large-scale demonstration programmes to define and build new infrastructure, train health professionals and paraprofessionals, and use technology to overcome onsite limitations in resources is an effective approach for cancer control.⁶ Two domestic bivalent HPV vaccines; objective, simple, and low-cost HPV tests; artificial intelligence assisted colposcopy; and optimising information platforms could reduce the barriers to cervical cancer elimination in China's low-resource settings. A government-supported health programme was launched in 2022–23 that included 18 sites with low health resources across nine provinces in central and western China. Explaining the data and experiences of these sites would help drive action to benefit all.

The Tibetan Plateau is the most challenging area for cervical cancer elimination in China, and it would be a milestone for women's health in China if actions are sustainably taken in this area and others low-resource settings.

We declare no competing interests.

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Case for a health equity framework in health technology assessment

Improving health equity is essential for both individual wellbeing and societal prosperity. However, health opportunities are not equally distributed, with life expectancy varying substantially across different areas in England with a 20-year gap for women and a 27-year gap for men between areas with the highest and lowest life expectancies.¹ These health disparities exacerbate economic and social inequalities. Although traditionally seen as a public health issue, there is growing recognition that the development and assessment of medicines can play a role in improving health equity. Indeed, reducing health inequalities is a core principle of the National Institute for Health and Care Excellence (NICE).

Health technology assessment (HTA) agencies influence patient access and ultimately population

health through evaluating new drugs and technologies. As focus on health equity increases, HTA must importantly consider how to routinely incorporate equity into evaluations, especially for conditions with evidence of inequalities. This initiative could in turn drive pharmaceutical companies to invest in evidence generation to show the potential benefits of medicines for underserved populations.

However, a challenge lies in quantifying the equity benefits of a drug or technology. Distributional cost-effectiveness analysis (DCEA) has emerged as a method to address this challenge, offering a more nuanced assessment by evaluating health benefits and costs across subpopulations.² NICE recently considered a DCEA for exagamglogene autotemcel (Casgevy), a treatment for sickle cell disease and transfusion-dependent thalassaemia, which disproportionately affect Black African and Caribbean populations, and Mediterranean, South Asian, and Middle Eastern populations, respectively. NICE's appraisal committee concluded that eligible populations face health inequalities and concluded that exagamglogene autotemcel could help mitigate them. Consequently, they were willing to accept greater uncertainty in clinical effectiveness data and adjust the acceptable incremental cost-effectiveness ratio, while being mindful of associated opportunity costs.³ This step marks a notable precedent for including quantitative equity assessments in HTA, a practice that has primarily been qualitative until now.

Routine use of DCEAs in HTA faces several challenges; health equity encompasses multiple domains that vary across diseases and countries. Racial and ethnic inequalities, for example, are more pronounced in some diseases such as sickle cell disease,⁴ whereas other conditions show the largest inequalities according

to income or deprivation. Furthermore, the intersection of these equity domains adds an additional layer of complexity and corresponding data challenges.

The inclusion, use, and value of real-world evidence (RWE) in medicines assessment have improved remarkably, largely due to initiatives such as NICE's RWE Framework.⁵ Building on this success, a collaborative health equity framework could further standardise and guide equity considerations in HTA, offering guidance on equity domains, dataset considerations, and methods to measure inequalities. This framework should be coupled with efforts to improve equitable access to and uptake of medicines. The UK's Voluntary Scheme for branded medicines pricing and access underscores this issue by committing to post-launch tracking of inequalities in the uptake of newly approved drugs, an approach that could be integrated into a proposed health equity framework.

Creating a health equity framework that embeds both qualitative and quantitative equity assessments within HTA could mark a meaningful step to sector-wide consideration of health inequalities. Since its inception, NICE has led in HTA innovation; now is the opportunity to continue pioneering by reimagining the value of health equity and enable health-driven prosperity.

JP-S is Head of Health Analytics and Partner at Lane Clark & Peacock; Chair of the Royal Society for Public Health; and reports personal fees from Novo Nordisk unrelated to this Correspondence. BO is Director of the National Healthcare Inequalities Improvement Programme at National Health Service England and also works as a general practitioner.

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Future-proofing Europe and Central Asia: a renewed focus on child and adolescent health

The data are clear: Europe and Central Asia are failing their children. Hard-earned reductions in child mortality in the region are reversing or stagnating. Mental health concerns have doubled since the COVID-19 pandemic, with one in four children younger than 18 years affected.¹ Immunisation coverage is decreasing or stagnant. Outbreaks of measles are reappearing.² An estimated 5 million young children are at risk of developmental difficulties, and with many identified too late, their contributions to society will be curtailed.³ One in three primary school children is living with overweight or obesity.⁴ Making matters worse, the impacts of these failures will be felt for decades to come.

Over the past decades, governments across Europe and Central Asia have greatly improved the health and wellbeing of their citizens, including children. But

ongoing and overlapping crises—including pandemics, the climate emergency, and conflicts—have absorbed much of political leaders' attention. We risk losing the gains we have made in a holistic approach to health across the lifecycle.

As Regional Directors for WHO and UNICEF in Europe and Central Asia, we call for a renewed focus on child and adolescent health and wellbeing. We propose the co-creation and adoption of a new regional framework for action for children and adolescents based on five key principles.

The first principle is increasing investment in child and adolescent health for long-term benefits. Early investments in children's health (including their mental health), development, and education yield lifelong benefits. The basis for ageing in good health is set in childhood, and any prevention efforts throughout the life course aimed at reducing the burden of non-communicable diseases need to begin in the early years. Countries that prioritise children's wellbeing have seen substantial health and economic advancements. Yet many European and Central Asian children still experience poverty and exclusion. Health and education sectors remain underfunded in many countries. Children deserve a long-term plan that reaches across political aisles and is sustained well past the next election cycle.

The second principle is the duty of care and protection to every child. Quality primary and specialist health care, access to nutritious food in and around schools, and support for families such as paid parental leave are essential to the health and wellbeing of both children and society at large. Standards of quality care need to be implemented widely, supported by well functioning health systems sustained by the necessary financial and human resources and effective governance. Making every

For more on the UN Inter-agency Group for Child Mortality Estimation data see <https://childmortality.org/> analysis