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research and services, health professionals will remain uninformed about how racism impacts women's reproductive choices and their fertility journeys and how racism may be perpetuated within the fertility setting. Understanding how belief systems, fertility knowledge, and cultural and religious influences intersect with racism, access, and individual health factors is the only way to meaningfully bridge the gap in fertility outcomes. Without such analyses, infertility and failed fertility treatment in Black and Asian women are likely only to rise.

Unsuccessful conception has negative psychological impacts for many women.[22] To continue to provide fertility treatment that does not fully benefit all women only ensures that inequality is further entrenched between those who can exercise their right to a family and those who cannot.

I am the Co-Chair of the Royal College of Obstetricians and Gynaecologists' Race Equality Taskforce. I have received speaker's fees from Diageo, Freuds, Whisteldown Productions, The Wing, and Visa UK on the topics of women's health in the workplace and inequality in women's health outcomes. I am the Director of Early Pregnancy Plus, a private ultrasound and pregnancy treatment service. I have received expert testimony fees for the provision of expert clinical negligence opinion for TMLEP, unrelated to the topic of this Comment. I am an adviser for Baby Lifeline and a Trustee for The Eve Appeal charities. The views expressed in this Comment are those of the author and not necessarily those of the Royal College of Obstetricians and Gynaecologists

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Will the COVID-19 crisis catalyse universal health reforms?

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The historian Walter Scheidel has argued that reductions in inequality have often emerged after war, revolution, state collapse, and plague.[1] On July 12, 2021, there were more than 4 million deaths from COVID-19 globally.[2] The disproportionate and unequal impact of COVID-19 on populations has brought renewed attention to deep inequalities. Will the impacts of COVID-19 galvanise efforts to reduce inequality?

One of the greatest inequalities globally is the inequity in the access to safe, effective health care without financial burden—universal health coverage (UHC). Historically, universal health reform has often been borne out of crisis. The Overseas Development

Institute reported 71% of countries made progress towards UHC after episodes of "state fragility",[3] and there are plenty of examples across the continents. In 1938, after the Great Depression, New Zealand's Social Security Act began its commitment to UHC. The National Health Service in the UK was founded in 1948 in the wake of World War 2. Similarly, France and Japan enacted universal health reform after the conflict. In the aftermath of Rwanda's genocide of 1994, the country's new leadership focused on health for all and expanded UHC.[4] Sri Lanka's publicly funded UHC system emerged from a devastating malaria epidemic,[5] and after the 2003 SARS pandemic, China launched health-care reform to achieve universal coverage of basic health care by the end of 2020.[6] In Thailand, decades of planning were realised with the launch of the Universal Coverage Scheme in 2002 after the Asian financial crisis.[7] It is therefore possible that, like other crises before it, the COVID-19 pandemic could catalyse UHC reforms, should global leaders choose to harness the opportunity.[8]

Indeed, some countries, such as Finland and Cyprus, are implementing ambitious reforms to extend health coverage during the pandemic. In Cyprus, the second phase of their publicly financed General Health Scheme (GHS) was launched in June, 2020. These reforms are popular, attaining an 80% approval rating in a national survey.[9]

US President Joe Biden has a clear opportunity to expand health-care access to more people. The USA and Ireland are the only two countries in the Organisation for Economic Co-operation and Development without a universal health system. While in Ireland attempts are being made to accelerate UHC through national Sláintecare reforms,[10] in the USA Biden's election stance on health care was for slow, incremental steps towards UHC.[11] But now, in 2021, there is growing momentum for UHC reforms at a state level, especially in New York. Furthermore, in 2020 63% of Americans polled agreed that it is the federal government's responsibility to make sure all people have health-care coverage.[12] If Biden does not harness this momentum, he could miss this unprecedented opportunity to bring UHC to the USA.

UHC is not only an option for high-income countries like the USA. Political leadership, and not a country's wealth, is a key determining factor in progress to UHC.[3] Consequently, the COVID-19 crisis might provide a political window of opportunity for leaders in low-income and middle-income countries to launch UHC reforms.

South Africa is a country where some universal health reforms already came from crisis. When the African National Congress came to power in 1994, it inherited an inequitable "two-tiered" health system.[13] One of the first major social policies of the then President Nelson Mandela was to launch universal free health care for pregnant women and children younger than 6 years. Yet, despite this advance, in the first decade of post-apartheid South Africa overall inequalities grew.[14] After the 2019 election, the new South African Government reaffirmed its commitments to ensuring that quality health care is available to all citizens, with National Health Insurance at the centre of policy development. Although this policy enjoys considerable public support, the financing reforms needed for wealthy citizens to subsidise the rest of the population are yet to be implemented. However, there are indications that President Cyril Ramaphosa could use the COVID-19 crisis to drive through these reforms.[15]

Handout/Getty Images

There is potential for rapid reform in other nations, too. In Pakistan, for example, Prime Minister Imran Khan has made clear his priority of establishing UHC in launching a welfare state, with some early reforms in certain provinces, as the country looks towards post-pandemic recovery.[16] In Kenya and Indonesia, COVID-19 might present the opportunity to turn previous commitments of their presidents to population-wide UHC into action as they approach the ends of their terms in office.

As in previous crises where leaders have needed to rapidly improve the welfare of all their people, enacting UHC makes sense from a health, economic, and political perspective. Now is the time to act to reduce inequalities that have been so instrumental in adverse outcomes in the pandemic so far. Political leaders need to prioritise UHC as countries gradually look ahead to recovery from the COVID-19 pandemic.

We declare no competing interests.

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Gendered ageism: addressing discrimination based on age and sex

Tara Moore/Getty Images

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The 2021–30 Decade of Healthy Ageing[1] aims to improve our functional wellbeing as we age. The UN and WHO have identified four main action areas to promote healthy ageing; one of these is to combat ageism, which perhaps needs to go further in highlighting the important intersection of age and gender.

Ageism, a term describing discrimination based on age, leads to negative experiences among older adults[2] and is a largely neglected social determinant of health.[3] It is important that we go beyond that single label to consider the neglected and pervasive impact of gendered ageism. Older women are negatively impacted by both their advanced age and their gender with far-reaching consequences for their health and wellbeing. Such ageism often renders older women largely invisible and is embedded in contemporary culture and social and economic policies.[4] Gendered ageism is also institutionalised in health-care practices.[5] This problem persists globally even though women make up the majority of the older population.

The social construction of gendered ageism reflects the importance given to being youthful[4] in combination with the dominance of patriarchal societal norms. A 2018 survey found anti-ageing views are especially harmful for older women, who feel pressured to hide their age and appear youthful.[6] While grey hair is viewed negatively for older women, it is regarded as distinguished for older men. The relentless marketing of youthful appearance projects intrinsically ageist and sexist tropes.[7]

Age discrimination against older women is evident in the workplace,[8] where it impacts women's recruitment, career opportunities, and pensions.[4] Across their lifecourse many women have been subject to discrimination in their dual roles as responsible for tasks in domestic spheres and as employees in the labour force. Women who worked often faced inequitable policies, such as loss of pension contributions during maternity leave or having unequal employment opportunities as they aged.[9] The effect of this gendered age discrimination resulted in women receiving 27% less annual pension payments than men in the Organisation for Economic Co-operation and Development countries,[1] impacting their future health and independence.

There is a strong gender dimension to ageism in relation to long-term care because women need more long-term care services than men.[10] This predominance of older women in congregate care reveals the delayed impact of gendered ageism as both a consequence of lifetime discrimination, whereby many women may not have the resources needed to afford care in their homes, and a failure to think beyond institutionalised forms of care for those women who have often provided care for others.[11]