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Equity in Access to Public Health

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Part I –Proceedings*

* Originally issued as Recommendations Arising out of the Technical Discussions on Equity in Access to Public Health (document SEA/RC53/18 dated 3 September 2000)

1. INTRODUCTION

Technical Discussions on "Equity in Access to Public Health" took place on 31 August 2000 under the Chairmanship of Dr Kyi Soe, Director-General, Department of Health Planning, Ministry of Health, Myanmar. Mr Mir Shahabuddin Mohammed, Joint Secretary (Public Health and WHO), Ministry of Health and Family Welfare, Bangladesh, was elected Rapporteur.

1.1 Introductory Remarks by the Chairman

Dr Kyi Soe opened the discussions by emphasizing the importance of equity in access to public health in view of its close relation with efforts to achieve health for all in the 21st century. Equity was the most salient feature of the HFA movement initiated by the Alma-Ata Declaration in 1978. In the *World Health Report 2000* also, equity was given considerable importance in the health system performance assessment. It was seen that 'equity' and 'equality' were used interchangeably both in the health field and outside. Similarly, the term 'access' need not necessarily imply 'having access to health care'. He hoped that despite the different perceptions and backgrounds of the participants, the meeting would deliberate on the topic in the spirit of "one WHO". The outcomes of these discussions would help facilitate the Member Countries in achieving health for all in the 21st century.

1.2 Introduction by Dr Rita Thapa, Director, Health Systems and Community Health, WHO/SEARO

Introducing the topic, Dr Thapa highlighted its significance. Countries of this Region had almost half of the world's total poor. She mentioned that 70% of all deaths and 92% of deaths from communicable diseases occurred among the poorest 20% of the people. There was evidence that 70% of the world's poor were women who suffered the most damaging and mutually reinforcing inequities of poverty and gender.

This affected women's health most disproportionately with the adverse effects transcending to the next generation as well. An adoption of the equity approach in public health would help to reduce such unfair gaps regardless of people's ability to pay, geographical location, sex, ethnicity and other variables. Four major international conferences during the last decade had addressed these issues of equity approach to health and health determinants. She hoped that the recommendations of the technical discussions, duly endorsed by the Regional Committee, would help guide the Member States in building a bridge to the 21st century by reducing the gap between the poor and the rich.

1.3 Presentation by Dr N. Kumara Rai, Regional Adviser, Health Systems Development, WHO/SEARO

Dr Kumara Rai stressed the importance of having a common understanding regarding the notion of equity and equality. Although these terms have different meanings, they are frequently used interchangeably.

Equity adheres to predetermined norms or standards which are considered fair or just when describing gaps, differences or disparities. These norms or standards vary from place to place, from time to time and from one community to the other. It was due to the difficulties in setting these norms or standards – usually laden with values or judgements – that the notion of inequality is more frequently used. Contrary to equity, equality does not take into account whether the existing gaps, differences or disparities are fair or just. In other words, we may say that inequity is unjust or unfair inequalities. Equity in health was defined by WHO as minimizing avoidable disparities in health and its determinants – including but not limited to health care – between groups of people who have different levels of underlying social attributes (income, gender, ethnicity, geography, etc). He emphasized the importance of differentiating equity in health with equity in health care.

He also explained the ambiguity regarding the term access. Having access to health care does not automatically lead to utilization. Based on

this, a conceptual framework was presented. This concept explains the transformation of potential access (or health system characteristics) into realized access or utilization, after a dynamic interaction with demand or felt need and various enabling factors such as ability and willingness to pay, travel time, quality of care, etc.

Dr Kumara Rai explained three views of equity, i.e. focus on the health of the most vulnerable, inclusion and narrowing gaps. He said that so far, only the European Region had selected the focus of equity on narrowing gaps between the poorest and the richest segments of the population.

Concluding his presentation he stressed two issues. First, the need for disaggregated data by various social attributes described above to be able to reflect the existing inequity in health and health care. For this purpose, routine household surveys seemed to be the only alternative. Secondly, the need to pursue equity in other sectors as well if we were aiming at attaining equity in health and health care. Hence, the challenge to the health sector was how to influence the other sectors, particularly the economic sector to put equity on their respective agendas as well.

2. DISCUSSIONS

The presentation was followed by a lively discussion. Practical country experiences were exchanged which further complemented the issues raised in the presentation. The major issues discussed were:

(1) Equity in health was construed as minimizing avoidable disparities in health and its determinants.

(2) The purpose of minimizing health inequities is to contribute to poverty reduction and promotion of economic development.

(3) Ensuring equity in health requires equity in other sectors as well. Thus, political commitment is needed essentially for all related sectors.

(4) There is a need to define the level of equity, i.e., equitable distribution of health care resources in relation to the specific country situation and the needs of nomadic populations, populations residing in remote mountain areas or islands, those in emergency situations and displaced persons.

(5) There is a need for total health sector reform for improving equity in health.

(6) Health sector reform shall give priority to the provision of an essential health care service package, specific to country needs, to all, regardless of their ability to pay and social attributes.

(7) In view of increasing globalization and privatization, there is an urgent need to adhere to ethical practices and standards of health care including certification of health institutions in both the public and private sectors. Preventive and promotive health services should also be included in private health institutions.

(8) There is a clear need for improving peoples ' access to health information.

3. RECOMMENDATIONS

(1) Political commitment is essential to reduce unfair gaps in health and health care, regardless of peoples 'ability to pay, geographical location, sex, age, ethnicity and other variables.

(2) Concerted efforts must be made from political and policy levels to redress the disparities in health and its determinants.

(3) Concerted efforts should also be made to set up/update and follow the standards of good health practices, and accordingly, institute accreditation of health institutions, both public and private.

(4) Private health institutions should provide not only curative, but also preventive and promotive health services.

(5) The process for a "total health sector reform " should be initiated. In order to plan for such reform, disaggregated data should be collected, analyzed and utilized in assessing gaps in health and health care.

(6) Provision of essential health care services of good quality to all, particularly the poor and vulnerable groups of populations, should form an essential component of health sector reform.

(7) Access to and use of essential health care services must be governed by needs rather than by individuals 'purchasing power.

(8) Countries of the Region need to further refine the conceptual framework, methodologies, indicators and related data, as required, to measure inequity in health and health care.

(9) Health information systems should be strengthened in the countries so that disaggregated data could be obtained to better reflect the inequity in health and health care.

(10) Partnership with other sectors should be further strengthened and operationalized to improve equity in health and its determinants.

Part II –Resolution, Agenda and Working Paper

Resolution*

The Regional Committee,

Recalling World Health Assembly resolution WHA51.7, adopting the World Health Declaration on Health for All Policy for the 21st Century; and also its own resolution SEA/RC50/R4 on the Declaration on Health Development in the South-East Asia Region in the 21st century,

Recognizing the need for ensuring equity in access to health and health care, particularly for women, the poor and other vulnerable groups,

Emphasizing the provision of essential health care for all, through appropriate health sector reform, and

Having considered the report and recommendations of the Technical Discussions on "Equity in access to Public Health" (SEA/RC53/18),

1. ENDORSES the recommendations contained in the report;

2. URGES Member States:

   (a) to develop and/or refine the conceptual framework, indicators, methodologies and tools for measuring inequity in health and access to health care;

   (b) to strengthen the national health information systems in collection and analysis of disaggregated data, particularly covering women, the poor and vulnerable groups, to enable formulation of policy options for enhancing equity in access to health care;

* SEA/RC53/R3

(c) to enhance accessibility and affordability of health care for the poor and vulnerable groups, and

(d) to intensify health sector reform efforts that contribute to reduction of inequity in access to health care, and

3. REQUESTS the Regional Director:

(a) to intensify cooperation and exchange of experiences with Member States and relevant health development partners in strengthening the national health information systems, with special emphasis on disaggregated data related to women, the poor and other vulnerable groups to help minimize inequity in health and access to health care, and

(b) to support Member States in research studies to help improve equity in health and access to health care particularly for women, the poor and other vulnerable groups.

Agenda*

1. Introduction
2. Equity, equality, access and efficiency
3. Measuring equity/inequity in health and health care
4. Factors affecting access to public health
5. Improving the access to public health
6. Conclusion

* Originally issued as document SEA/PDM/Meet.37/TD/1.1 dated 23 August 2000

Annotated Agenda*

1. INTRODUCTION

- Speaking the same language regarding equity, access and public health
- Equity as the most salient feature of Health For All has not been achieved satisfactorily in the year 2000
- WHO Corporate Strategy implicitly reflects the need to improve equity in health
- Equity is one important aspect in assessing health system performance

2. EQUITY, EQUALITY, ACCESS AND EFFICIENCY

(a) Equity

- General definition of equity
- WHO definition on equity in health and health care
- Three views of equity

(b) Equality

- General definition of equality
- Easiest way to memorize the difference between equity and equality

* Originally issued as document SEA/PDM/Meet..37/TD/1.2 dated 23 August 2000.

(c) Access

- Elaboration on various types of access – potential, realized, equitable and inequitable access – with emphasis on potential access considered as the supply side and realized access as the actual use/utilization of health care
- Utilization as a proxy for measuring access
- Needs differentiated into perceived/felt need or demand
- Transformation of potential access into realized access or utilization (using a diagram)

(d) Efficiency

- Pursuing equity might conflict with efficiency

3. MEASURING EQUITY/INEQUITY IN HEALTH AND HEALTH CARE

- The three goals of the Health System do not include Access
- Data from some countries as an example for showing whether Inequity/Inequality exists

4. FACTORS AFFECTING ACCESS TO PUBLIC HEALTH

- Availability of health facilities
- Ability and Willingness to pay
- Quality of care
- Globalization
- Privatization

5. IMPROVING THE ACCESS TO PUBLIC HEALTH

- Efforts should be directed particularly towards overcoming factors impeding access

- Improving access in a broad sense is actually improving the four functions of the Health System, namely, resource generation, financing, provision and stewardship

6. CONCLUSION

- Equity as a longstanding issue since the Alma-Ata Declaration in 1978, is reiterated by the WHR 2000
- Need for specifically setting health and health care targets for the poor which necessitate the availability of disaggregated data
- Recommendations leading to a draft resolution to be considered by RC53

Working Paper*

1. INTRODUCTION

During the last two decades, after the adoption of the health-for-all goal and primary health care (PHC) approach by all WHO Member Countries, there has been progressive improvement in health development. However, the growth has not been equal showing many gaps in health status both among and within developing and developed countries. Routine health information, which usually covers national average figures often blurs. Equity in health care has always been placed high on the public policy agenda. Evidence from many studies show that equity in health is easier to achieve, when there is equity in other fields, particularly in income and education.

The health-for-all goal was based on the fundamental principles of equity, social justice and solidarity. The notion *"for all"* clearly reflects equity. The PHC approach also provided the key route to make available affordable universal coverage of health care to all, particularly those excluded by many health systems. Although primary health care facilitated the wider distribution of health care by geographical area or level of care, its responsiveness was not adequate. Its main focus was on "presumed" needs of the people rather than on perceived demand. The shortcomings of health systems based on primary health care, in terms of staff training and deployment, provision of essential supplies and equipment and supportive staff supervision and referral services were viewed as major constraints. The problem was not actually that of the

* Originally issued as document SEA/PDM/Meet.37/TD/1.3 dated 23 August 2000.

PHC principle and approach, but its inadequate application. This was mainly due to limited political commitment resulting in limited resources to fully operationalize it. This led to the ushering of a *new universalism*, i.e. provision of high-quality essential health care for all, rather than all possible care for the whole population.[1,2]

Access to health care was defined as the possibility of obtaining health care when it is needed.[3] Others classified access by different means or potentials, such as potential access, realized access, equitable access, inequitable access, effective access and efficient access.[4] *Potential access* is a situation where the characteristics and resources of health systems influence the use of health services. *Realized access* is the situation where available health care services have been actually utilized. *Equitable access* is the distribution of health services determined by social, economic and demographic characteristics and need. *Effective access* is the use of health services that improve the health status or satisfaction. *Efficient access* is the use of health services that minimizes the cost of health services and maximizes the health status or satisfaction.

Public health is viewed from a broader perspective. It is not just preventive, promotive, curative and rehabilitative measures but also covers the services provided by government or public health institutions. It comprises comprehensive health care, covering all aspects of health care provided by both the government and the private sector. WHO's new approach for *measuring health system performance* stresses the importance of measuring *equity* in *health status*, *responsiveness* and in *financing* of health care.[2] It amplifies that any health system should strive for *horizontal equity* –i.e. providing health care (both personal and public health) to all those who have the same health need –as well as for *vertical equity* –providing preferentially to those with the greatest need.

Considering the importance given to this new approach, the concept has been expanded in this paper. The technical discussions on this could lead to the recommendations not only related to equity in access to public health, but to also cover the other measurements of health care mentioned above.

2. EQUITY, EQUALITY, ACCESS AND EFFICIENCY

Before proceeding further, there is need for a general understanding of the meaning of equity, equality and access.

(1) **Equity** is an ethical concept that eludes precise definition. Synonyms are *social justice* and *fairness*, which again, could be taken to mean differently by people at different times. Equity usually deals with a predetermined standard or norm, which is considered "just" or "fair".

Two examples:

- A salary ratio of 1 to 10 between the highest and the lowest-level category of civil servants is considered *fair* in *country A* but *not* in *country B*.
- If providing a *cheap* health intervention to *everyone* in a district will *save 100 lives*, or providing *more expensive* intervention to *half the population* in the same district chosen at random will *save 110 lives at the same cost, the public* would view the *universal* intervention *option* as the *more equitable*. *Specialists in decision-making* would tend to favour the second, for more effective use of available funds (because it saves more lives).

There are three views of equity:

- *Focus*: Equity in health mainly *focuses* on the health of the *vulnerable* population in absolute rather than relative terms. A policy or programme aimed at improving the health of the most vulnerable would be seen as being *equitable*.
- *Inclusion*: No one in the community should be left out. In this view, a health policy which does not provide health care to certain population groups, e.g. people living in thinly- settled, remote mountainous, island or desert areas, would be *inequitable*. Even though higher investment may be required to provide health care to these underprivileged populations, the extra investment should not be used in other places for the sake of efficiency.

- *Narrowing gaps*: Equity measurement identifies the relative and absolute gaps of health state. Thus a policy that improves the health *of the best off more than anyone else* would not be considered equitable.

(2) **Equality**: Equity should be differentiated from equality. Equality does not take into account whether the existing disparity/gap/difference is "fair or just". Simply, inequity is unfair or unjust inequality.

In practice, the terms, *equity and equality are used interchangeably*. Social scientists and economists use these terms more frequently. They tend to use *inequality* more due to the difficulty in setting the agreeable standard or norm for *inequity*.

Equity in Health: The World Health Organization has operationally defined "equity in health" as "Minimizing avoidable disparities in health and its determinants – including but not limited to health care – between groups of people who have different levels of underlying social attributes".[2]

Differences in social attributes are reflected by the political, social, economic, geographic, gender, ethnic and age differences. Health or health status is determined *not only by health care,* but also by *other non-health determinants* such as social status, education and economic level, gender and environment, etc. Thus minimizing the disparities in health between different groups requires special efforts on the part of the health sector to deal with disparities in risk factors, which, in turn, arise from other disparities such as socioeconomic and gender. Further efforts are needed to reduce other disparities through intersectoral action. Hence, achieving equity in health will be easier if there is equity in the other determinants of health as well. European experiences show that even in relatively affluent nations that emphasize equity in access to health services, there are *significant disparities/gaps/differences* (thus inequity) in health status such as those reflecting more fundamental social disparities in the socioeconomic status, education, and working and living conditions.

WHO's definition "equity in health" actually encompasses two different aspects.

- *Equity in health (health status)* means the *attainment by all citizens* of the highest possible level of physical, psychological and social well-being.

- *Equity in health care* means that health care resources are allocated according to *need;* health care is provided in *response* to legitimate expectations of the people; health services are received according to *need* regardless of the prevailing social attributes, and payment for health services is made according to *the ability to pay*.

The notion of *need* needs clarification. Ideally, the need should be *assessed,* i.e. the need *identified by health professionals* through various means of assessment. However, in most instances, it is the *perceived/felt need* or *demand.* This is because perceived need is easier to measure, although it is less reliable and greatly influenced by the educational, economic and cultural background of the individual or the community.

(3) **Access:** Equity in health care implies a commitment to ensuring high quality of realized access or utilization of health services, according to needs, for all.

Measuring the realized access or utilization provides a better picture of the situation compared to potential access. Table 1 shows the "Health Systems 'Characteristics" as a measure of potential access, that is actually the supply side. It is better to separate the 'Enabling Characteristics" under the Enabling Factors" as shown in Annex 1. Realized access or utilization is the function of both supply and demand. Hence, potential access will be transformed into realized access if there are enabling factors such as *ability and willingness to pay*. Other factors are depicted in Annex and discussed in Section 4.

Table 1. Different types of access measures[4]

Type	Measures	Examples
Potential Access		
Health systems Characteristic	Capacity Financing	• Doctor/population ratio • Hospital bed/population ratio • Per capita expenditure for health services
Enabling characteristics	Personal resources	• Per cent of population with health insurance • Income, Health Insurance • Coverage
Realized access		
	Type of services Site of services Purpose of service	• Ambulatory Inpatient • Physician's office; Health centre; Hospital • Primary care • Secondary care • Tertiary care
Equitable access		
	Services distributed according to perceived patient need Services distributed according to social advantage Services distributed according to enabling characteristics	• Symptoms • Pain, General health, Race/ Ethnicity • Education • Occupation • Income • Health Insurance • Coverage

(4) **Efficiency**: As mentioned earlier, in the short term, pursuing equity in health and health care might conflict with efficiency. Examples are:

- Stason and Weinsten (1999) in USA found that limited resources available for the detection and treatment of hypertension could be used more efficiently for treating noncompliant patients who are already in the health care

system rather than screening to discover new cases not yet receiving any care.

- Gordon Rich et al., (1976) in Great Britain, designed a method to screen schoolgirls for asymptomatic infections of the urinary tract. They studied two methods of screening, one much more efficient than the other. The cost per case found by one method was about one-third that of the other. They also discovered, however, that the more efficient method, which relied on family involvement and therefore required an intact social support network, tended to find cases from the middle class rather than the poor, lower class cases.

- Providing health services to the *poor* and *marginalized* groups who live in very remote areas is certainly *less efficient* than providing similar care to the better-off, living near the health providers.

Arguments for equity in health and health care must be based on *achieving long-term economic capacity and real productivity.* At times, the fastest way to improve aggregated indicators of growth may be to give more to the better-off, because they are often best equipped to be immediately productive with a given health input. But this will leave the worse-off behind, limiting the capacity for long-term development of society as a whole. Short-term and unsustainable efficiency gains are often used to *justify inequitable decisions* because short-term gains are more visible than long-term progress.

3. MEASURING EQUITY/INEQUITY IN HEALTH AND HEALTH CARE

Equity or equality is an important aspect for measuring the health system goals. This is evident from the efforts devoted to measure the ***level of equity*** of all three intrinsic goals of the health system. This is in conformity with continuous efforts to achieve *Health for All*, with *equity* and/or *social solidarity*.

The generic health systems, as enunciated in the World Health Report 2000, have three *intrinsic goals,* namely:

- *Health Status:* expressed as healthy life expectancy or DALE (Disability Adjusted Life Expectancy), meaning *less-than-perfect healthy life years lived*;
- *Responsiveness:* response of health systems to the legitimate expectations of the people, and
- *Fairness in financing:* fair financial burden on the people.

The level of attainment of health status and responsiveness are measured using the *average national figure,* depicted by *aggregated data.* Its *distribution across population groups,* which is a measure of equity, using *disaggregated data* as mentioned earlier is applied to all goals.

Access to health care*,* although used frequently in planning and evaluating health services, is not included in these three intrinsic goals, simply for the purpose of limiting the number of goals to manageable figures. Most available information on "access to health care" is obtained from household surveys and the data is disaggregated across the income quintile or the income decile. Routine data collected from health facilities in most instances do not provide such information. Some data showing *equality* in realized and potential access to health services are illustrated briefly. Realized access is measured using utilization of health services by the income quintile or the income decile as a *proxy.*

Figure 1 shows that wealthier population groups (fifth quintile) have a higher probability of *obtaining health care* when they need it, except in Kyrgyzstan. It clearly indicates that the wealthier groups are utilizing more health care as compared to the poor. If we use *perceived need* (where the rich usually have higher needs than the poor) as the basis for providing care in line with the pursuit of equality, we may say that there is no *inequality* in the utilization of health care in those eight countries. But, if we use *assessed need*, the poor should have a higher need for health care than the rich; thus *inequality* is observed.

Figure 2 shows that wealthier groups (fifth quintile) are more likely to be *seen by a doctor* than poorer groups except in Kazakhstan and Kyrgyzstan. Figure 3 indicates that there are no clear patterns in terms of the proportion of those who are ill and treated in *hospital.* In these eight countries, hospitals are predominantly public. Thus the rich, such as in South Africa, use less of hospitals compared to the private doctor.

Figure1. Percentage of sample seeking care when ill (around 1995)

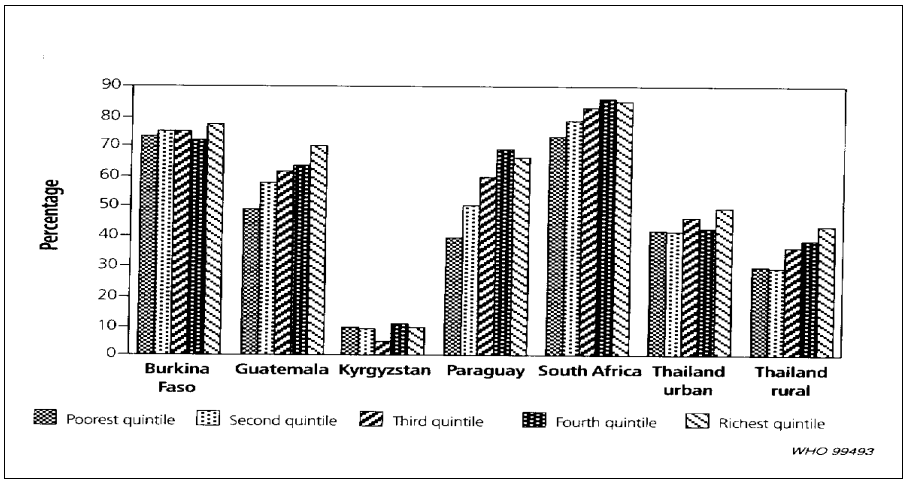


Figure 2. Percentage of those seeking care that are seen by a doctor

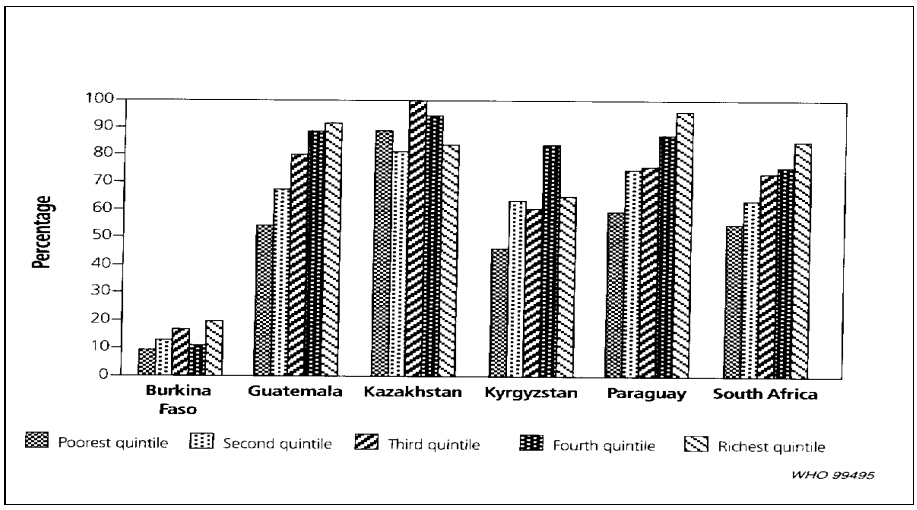
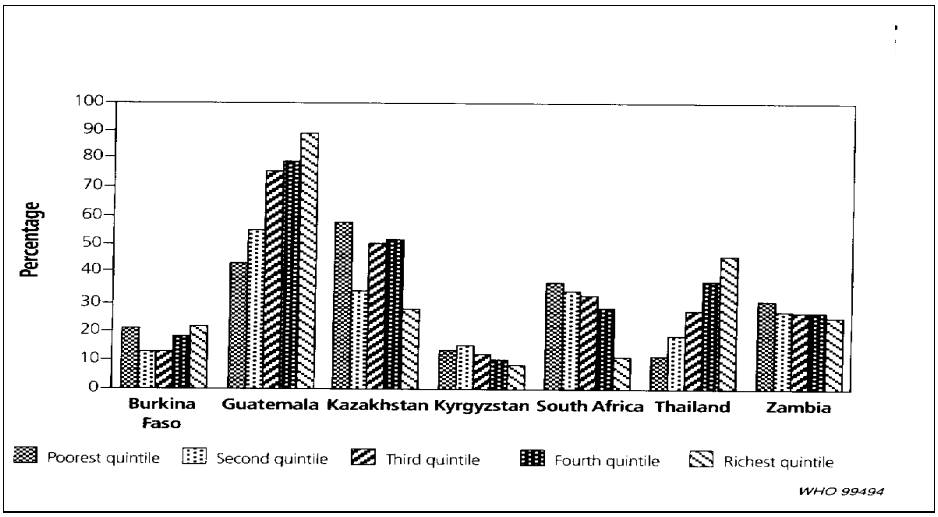


Figure 3. Percentage of those seeking care that go to a hospital (around 1995)[5]



Similar data from Malaysia as illustrated in Figure 4 illustrates the share of total inpatient visits by quintile of household per capita income. The year 1984 compared to 1974 saw a *more equitable* utilization of inpatient care. The poorest (quintile 1) used more inpatient care compared to the richest (quintile 5)

Figure 4. Use of inpatient care, by income quintile, in Malaysia[6]

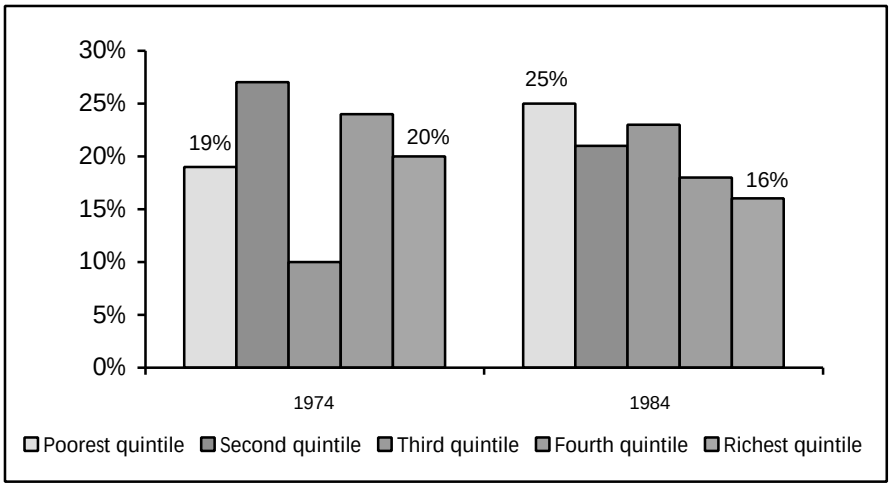


Table 2 shows the *inequality* of *out-of pocket expenditure as a percentage of household income* after reimbursement in Thailand. The poorest income quintile, which reported the highest rate of acute illness and hospitalization, had high annual health expenditure relative to income. The shares of health expenditure by educational status and health benefit coverage of the household head are more reasonable. After reimbursement, relatively high shares were devoted to health by households whose heads had only primary education (3.4% of household income), held low-income cards (6.1%) or had no health benefit cover (4.6%).

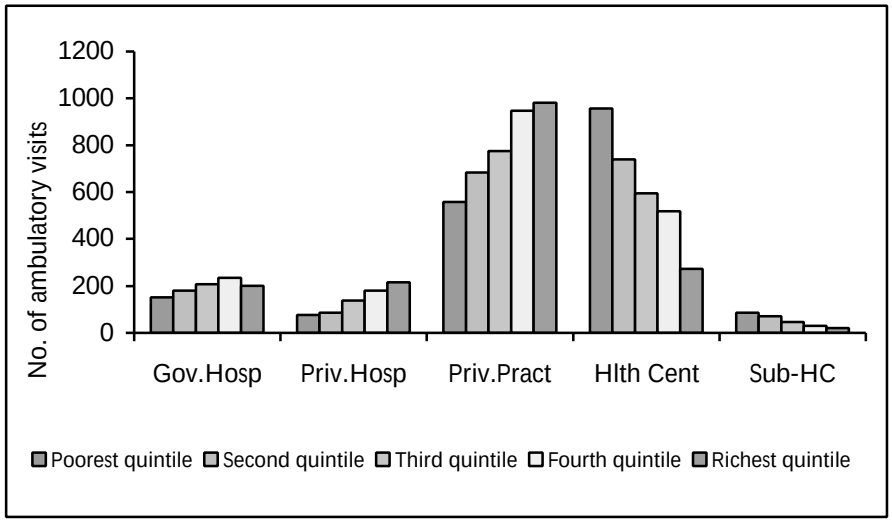
Table 2. Annual out-of-pocket expenditure by socioeconomic group and health benefit cover (1991-1992) in Thailand[7]

Socioeconomic Group	Health Expenditure*
Household income quintile	
1 - Poorest quintile	21.2
2 - Second quintile	2.6
3 - Third quintile	1.9
4 - Fourth quintile	0.9
5 - Richest quintile	2.1
Household head education	
No education	1.0
Primary	3.4
Secondary	2.9
Vocational	0.7
University	2.2
Household head s benefit	
Uncovered	4.6
Civil servant	1.7
State enterprise	2.3
Veteran and volunteer	1.5
Low income card	6.1
Social security	0.6
Private employer	0.3
Private insurance	1.7
Total	2.6

* As percentage of household income after reimbursement

Figure 5 shows that in Indonesia the rich use more ambulatory care in hospitals, both in government and private institutions, as well as the services of private practitioners, as compared to the poor. On the other hand, the poor use more services of public health institutions (health centres and sub-health centres) that are much easier to access and which provide simpler and cheaper services. It is thus clear that inequality in ambulatory care exists.

Figure 5. Use of ambulatory care by income quintile in Indonesia (x1000), 1998



The National Sample Survey Organization (NSSO), carried out the analysis of household data on health care utilization and expenditure for the period 1995-96 in India[8], and revealed that the *proportion* of the total *cost of treatment* to *annual per capita consumer expenditure* varied between 40% in Kerala to 160% in the poorer states. In contrast, in the top 10% of the population, such proportion ranged between 5 to 40%. These figures clearly show significant disparity/gap/difference or *inequity* between the worst-off and the well-off.

4. FACTORS AFFECTING THE ACCESS TO PUBLIC HEALTH

(1) *Availability of health facilities*, that is, when they are within easy reach, both from the physical and financial point of view, is part of the measurements used for *potential access*.

- The survey data in *South Africa* reveal that the poorest one-fifth of the population have to travel almost two hours on an average to obtain medical attention, while people in the top quintile travel only for 34 minutes.
- In *Sri Lanka*, by contrast, people in the poorest quartile travelled 4.7 km on an average to obtain medical attention, while people in the richest quartile travelled 3.3 km on an average.
- In *Ghana*, simulations suggest that a *reduction* of 50% in the *distance* to public facilities would lead to a doubling of the use.
- In *Nigeria*, the total facility expenditure per capita in the population served was found to significantly influence the choice of facility as well as the choice of whether or not to seek care.
- In *Malaysia*, the number of *nurses per capita* was found to have a significantly positive effect on the use of prenatal care services.

(2) Besides perceived need, *ability and willingness to pay* are essential to transform potential need into realized need. Even in the case of *free service*, other factors play an important role in affecting the utilization of public health or health services. A different cultural background, religion and language, and a difference in perception regarding health and illness between providers and users, also significantly influence utilization. The situation is further compounded by inadequate consideration being given to the gender issue. For instance, services that are not responsive to women's needs, will ultimately lead to lower utilization among them.

(3) *Quality of care* in terms of availability of *drugs*, *attitude* of *health staff*, *condition* of health facilities and *opening hours* also greatly influence realized access or utilization.

- In *Ghana*, it has been estimated that if the percentage of public facilities with available drugs increased from 66% to 100%, the use of these facilities would increase by 44%.
- In *Sri Lanka*, it has been estimated that households are more likely to bypass local facilities if, compared to a more distant facility, the bypassed facility has inferior drug availability, is *open for fewer hours* per week and has *a poor appearance*.
- *Long waiting time* and *staff absenteeim* were identified as factors which accounted for low utilization in El Salvador.
- In *Nigeria*, the *attitude* of health staff who were perceived as harsh, rude, uncaring and off-hand, was cited as a factor leading to low utilization.

(4) *Globalization* or liberalization of international trade within the context of multilateral international trade agreements such as GATS (General Agreement on Trade and Services) and TRIPS (Trade Related Aspects of Intellectual Property Rights), if not well anticipated and prepared for, will impede efforts towards improving equity in access to health care. Making the free movement of health personnel to and from other countries possible through GATS, might accentuate the present imbalance of human resources for health, especially those needed for rural areas. This would definitely affect the access to health care by the poor. When TRIPS becomes effective in many developing countries, the prices of pharmaceuticals will increase considerably, straining the already scarce health resources. As mentioned earlier, the availability of good quality drugs is an important factor influencing access to health care.

(5) *Privatization* without good *stewardship or governance in health* (guiding, regulating and overseeing) by the respective governments has proved to be an important causative factor for the spiralling of health care costs and the poor being the worst affected. Many countries, for long, have been trying to find an optimal public-private mix to tackle this situation.

5. IMPROVING ACCESS TO PUBLIC HEALTH

Efforts to improve equity in access to public health should be based on the *various evidence* mentioned above. Improving the availability of health facilities or improving the potential access with the ultimate objective of improved utilization or realized access depends on the ability to improve the health system's resource generation, financing, provision and stewardship.

Health systems are not limited to the set of institutions that regulate, finance or provide services but also include a diverse set of organizations providing inputs to health services, particularly human resources, physical resources (facilities and equipment) and knowledge. These organizations include universities and other educational institutions, research centres, construction firms and a vast array of organizations producing specific technologies such as pharmaceutical products, devices and equipment.

Provision of services refers to the combination of various inputs - human resources, drugs and facilities - in a production process, the output of which is health services.

Financing comprises *revenue collection*, *fund pooling* and *purchasing* of services. Revenue collection refers to mobilizing money from households, firms, governments and donor agencies and is conducted through various mechanisms, out-of-pocket payment, voluntary insurance/managed care, compulsory social insurance, general taxes, donations from NGOs and transfer from international agencies. Once funds have been mobilized, the second part of the financing function is accumulating those revenues in a fund to pool the risk. Some forms of financing involve no pooling, as with out-of-pocket payment. In SEAR countries, out-of-pocket spending accounts for a higher proportion (around 60% to 75%) of the total health spending. Achieving greater financing fairness or *financing equity*, implies solidarity in financing (equity and/or social solidarity are the most important features of HFA), achievable only through risk-pooling. In this risk-pooling mechanism, there is a cross subsidy from the rich to the poor and from the healthy

groups to the sick groups. The evidence from many health systems shows that prepayment through insurance/managed care systems leads to greater financing fairness. Once revenues have been collected and pooled, they are allocated to institutional or individual providers to purchase services rendered.

Stewardship as a new concept broadens the conventional notion of regulation - setting rules –by encompassing two additional components: ensuring a level playing field, for example by providing consumers with adequate information- *to reduce the information asymmetry*- to guide their decisions in the health system and providing strategic direction to the health system as a whole. In conclusion, stewardship can ensure that access to health care for the poor is in keeping with their needs.

Decentralization, currently taking place at a higher pace could become another important avenue for improving the access to health care for the poor, through better planning and provision of health care tailored to local needs.

Finally, the WHO Corporate Strategy, aimed at reducing excess mortality among the poor and the marginalized populations, provides a strategic direction for improving health system attainment and performance. With this strategic direction, health systems could be better guided into providing a better access to the poor and the marginalized groups, ultimately leading to better health and better equity. In fact, WHO has a high commitment towards treating health, which is regarded as an entry point for breaking the vicious cycle of poverty, as an important element of its poverty alleviation activities.

6. CONCLUSION

Equity has become a long-standing issue in health and health care delivery since the Alma-Ata Declaration in 1978. The World Health Report 2000 reiterates this issue by taking equity and efficiency as the most salient features of Health System Performance.

However, reducing inequity in health requires not just development of indicators and measurement of the problems, but, more importantly, a policy, which puts equity on the agenda and encourages those, especially in economic decision-making positions, to consider the equity implications of their policies. The health sector has an important advocacy role to play here, but needs the relevant information and analytical skills to present it effectively.

Another reason why the HFA movement or PHC approach has not been very successful in addressing the equity issue might be the inability (unwillingness?) to specifically setting various intervention targets related to the poor. Besides, the dearth of information and inadequate analytical skills to provide disaggregated data to better reflect the health situation across different social attributes might have further hindered the efforts to fully achieve the HFA targets by the year 2000.

Member Countries of the WHO South-East Asia Region may resolve to further improve data collection and analysis to provide various disaggregated indicators related to improving the equity in access to public health/health care, as well as to the achievement of the goals of their respective health systems.

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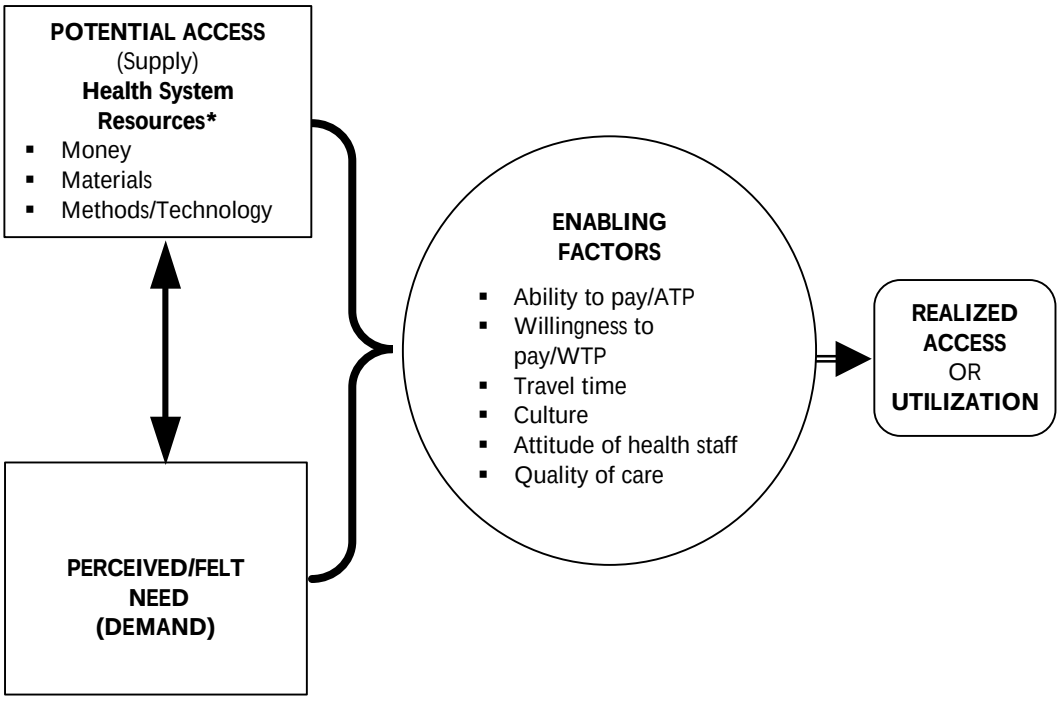
Annex

TRANSFORMATION OF POTENTIAL ACCESS INTO REALIZED ACCESS OR UTILIZATION



* Example: Doctor/Nurse per 1000 population
Per capita expenditure on health
Hospital bed per 1000 population
Mobile clinic per 100 000 population
X-ray equipment per 1000 population