

Summary Article: **Health Care Access**

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Health care can be neither universal nor equitable if it is less accessible to some sections of society than it is to others. *Equitable access* refers to access appropriate to peoples' health needs, their personal situation, and their broader socioeconomic context. *Equal access* refers to access that is the same for everybody.

In the contexts of low-income countries, where resources are scarce, marginalized or vulnerable people may experience greater social exclusion and have their right to health undermined to a greater extent than in wealthier countries. Thus, Leslie London argues that “developing countries are faced with declining expenditures on health and social services, increased burdens posed by both communicable and non-communicable diseases and economic systems that are *not* orientated to fostering sustainable development for the poorest and most marginalized” (2007, p. 1). This directly challenges the UN call for *Health for All* with its implicit assumption of universal and equitable access to health care.

The Health for All concept asserts that attaining health for all as part of overall development starts with primary health care based on “acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford” (Declaration of Alma-Ata, 1978). Since that declaration, all countries have been urged to consider the Health for All concept when formulating policies and action plans. It was believed that, by interpreting Health for All in a national social, political, and developmental context, each country would be able to contribute to the global aim of health for all by the year 2000.

Internationally global health is now focused on achieving the Millennium Development Goals (MDGs) by 2015. Early gains toward these goals have arguably been with those who have had easier access to health care; subsequent gains are only going to be achieved if they can address the challenges faced by a range of vulnerable groups. Equitable health care access is thus critical for achieving the MDGs.

Vulnerability

Vulnerable groups may be especially disadvantaged by difficulties in access. Vulnerable groups, according to J. H. Flaskerud and B. J. Winslow, are “social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality” (1998, p. 69), and this may include women, children, elderly people, ethnic minorities, displaced people, people suffering from some illnesses, and people with disabilities. Although different groups of vulnerable people present similar challenges for their equitable access to health care, there are also distinctive challenges presented by different groups. This can be illustrated by the situation of people with disabilities.

The World Report on Disability (WHO, 2011) states that 15% of the world's population, or 1 billion people, have a disability and constitute the world's largest minority, of which 80% live in low-income countries. With one in five people living below the poverty line having a disability and 80% of persons with disabilities living in low-income countries living on less than US\$1 per day, there is a need to address the social exclusion and health care access challenges facing this group of people, especially in low-income countries.

The UN Special Rapporteur for Disability has stated that there are 62 countries with no effective

health and rehabilitation services, and the World Health Organization (WHO) has found that only 5-15% of persons with disabilities can access assistive devices in low-income countries, with only 3% of all persons with disabilities getting the rehabilitation services they actually need. The World Report on Disability also notes that the number of persons with disabilities is rising as a result of conflict, malnutrition, accidents, violence, and communicable and non-communicable diseases, including HIV/AIDS, aging, and natural disasters.

Dimensions of Access

The General Comment of the United Nations Committee on Economic, Social and Cultural Rights can be applied to health care access to better understand facilitators and barriers. The indicators of good services, as outlined in the General Comment, encompass four intersecting elements. *Accessibility* refers to the need for health facilities, goods, and services to be accessible to everyone without discrimination, and within the jurisdiction of the state. This first element of accessibility can be further broken down into the related dimensions of nondiscrimination, physical accessibility, economic accessibility (affordability), and information accessibility. The second element stressed in the General Comment, *availability*, concerns the quantity of services available; so well-functioning public health and health care facilities, associated goods (such as medicines) and services (such as pre-natal examinations), as well as programs (such as nutritional support), have to be available to the general public in sufficient quantity to meet their needs. The third element, *acceptability*, stresses that all health facilities, goods, and services must be respectful of medical ethics, be culturally appropriate, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned. The fourth and final element of the General Comment refers to *quality*, which means that health facilities, goods, and services must be scientifically and clinically appropriate to provide services of good quality. This final element is perhaps the least well developed but one of the most important and strongly related to the drive for more evidence-based health care practice. Within each of the above-mentioned elements, “there are a number of supply- and demand-side factors and multiple layers of determinants underlying each factor” (Gilson & Schneider, 2007, p. 28).

Systems Strengthening

Addressing inequities in access to and quality of care for people with disabilities is a prima facie case for a systems approach, where the degree of coherence and connectivity among different aspects of health, welfare, transport, and other public services is critical. In fact, as a result of the broad range of service needs and their difficulties accessing health services, the experiences of people with chronic diseases and disabilities may be a good probe of the effectiveness of inter-sectoral collaboration. Furthermore, the new guidelines for community-based rehabilitation (CBR), jointly launched by the WHO, United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Children's Fund (UNICEF), International Labour Organization (ILO), and International Disability and Development Consortium (IDDC; a consortium of 23 international civil society organizations) in 2010, call for much greater cross-sectoral working. As such the crisis in both the number and productivity of health workers in low-income countries as well as in other public service sectors continue to undermine severely the possibilities of achieving equitable access to health care (MacLachlan, Mannan, & McAuliffe, 2011).

Service

Even among those who can access health services, different groups receive different qualities of care. Furthermore, efforts to improve the efficiency of health services, for instance, through pay-for-

performance programs for clinicians, may actually further marginalize those groups least well served by existing health systems. Access to mental health services is particularly problematic even in high-income countries. In low-income countries, it is recognized that it is not simply a matter of providing more clinicians but that “population-wide progress in access to humane mental health care will depend on substantially more attention to politics, leadership, planning, advocacy, and participation” (Saraceno et al., 2007, p. 1167), thus, recognizing the primary role that community health care and informal health care resources can play. Vikram Patel and colleagues also note in the context of mental health services that people who are privately insured or represent more powerful groups in a population have better access not only to care but also to a broader range of treatment options. They therefore recommend the equitable allocation of resources enabling access to health care services for those groups facing the highest levels of disadvantage, such as impoverished or displaced communities. As D. McIntyre and colleagues noted, “Research into alternative health care financing strategies and related mechanisms for coping with the direct and indirect costs of illness is urgently required to inform the development of appropriate social policies to improve access to essential health services and break the vicious cycle between illness and poverty” (2006, p. 860) in low-and middle-income countries.

Increasing Health Care Access

Access needs to be addressed on the ground in health care facilities but also in society more broadly. In the latter case, this means having health care policies that promote accessibility. EquiFrame is a policy analysis instrument designed to evaluate the extent to which social inclusion is promoted and human rights are upheld within health policy documents and to offer guidelines for further development and revision, where appropriate. It details 21 core concepts of human rights in analyzing health policies. Concepts include quality; efficiency and access; individualized and appropriate services; service coordination and collaboration; service integration; and cultural responsiveness. EquiFrame also considers the coverage of 12 vulnerable groups (including ethnic minorities, displaced people, those living away from services, individuals suffering from chronic illness, and people with disabilities). EquiFrame facilitates policy analysis and benchmarking against other policies nationally and internationally. Hasheem Mannan et al. (2011) clearly demonstrate that there is considerable variation in policies, for instance, the Drug Policy and National Medicine Policy in Sudan and Malawi. Both the number of core concepts mentioned and those where specific actions identified or an intention to monitor was expressed were greater in the Malawian policy (66% and 76%) than in the Sudan policy (38% and 38%).

An approach to increasing access on the ground in terms of human rights and social inclusion is BIAS FREE (Building an Integrative Analytical Framework for Recognizing and Eliminating Inequities). M. Eichler and M. A. Burke have operationalized a key insight that many biases and prejudices derive from social hierarchies. The BIAS FREE framework addresses the intersection of biases that derive from hierarchies based on ethnicity, gender, disability, age, class, caste, socioeconomic status, religion, sexual orientation, geographical location, and immigrant/refugee status, among others, and it considers how these play out in the overall health and well-being of people.

A Model of Health Care Access

Although there is no generally accepted model of access to health care, some key features of access are apparent. Although only “conventional” (“Western”) health care access features are discussed here, these would also apply, at least in some respects, to “alternative” or “traditional” health care. First, there has to be a perceived *reason* to access health care; that is, a problem for which access to health

care can provide some help. Then there has to be an *inclination* to access health care; some people, perhaps for religious or other reasons, may simply not wish to use health care facilities, even when they are available to them. Given a reason and an inclination, then there must be *means* for getting to the service, which could include transport or the cost of seeing a clinician, for instance. With sufficient means to be at the health facility, the staff must then be *receptive* to the person attending, that is, not disadvantaging them because of non-health-related characteristics or attributes, such as poverty, ethnicity, disability, or gender. The treatment offered must then be acceptable, which, along with the treatments' intrinsic efficacy, will determine its overall *effectiveness*. Finally, service providers should then be able to *follow up* with the person in their community; this provides for more accurate evaluation of the longer term effectiveness of interventions, may prevent the reoccurrence of problems or the development of secondary or iatrogenic complications, as well as develop the outreach function of accessible health care.

See also:

Diseases, Global Health and Nutrition, Health Care Systems, Human Rights, International, Inequality, Global, Pharmaceutical Sector, Public Health, Viruses and Diseases, Emerging, World Health Organization

Further Readings

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