

When is Access to Health Care Equal? Some Public Policy Issues

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The issues of equality of access to health care has two related questions - access whom and access to what? They seem to have a simple answer: there should be access to health care services for anyone in need of it. Specially, it means that, non-medical features of individuals (such as their community, sex, geographical location, or ability to pay) should not determinate their access to health care. While public policy in the past has tended to remove some of the important barriers in access to health care, it has had to face more acutely the question, access to what. Whether or not policy-makers believe greater intervention by the state, or in market forces for providing health care, they should be concerned with the following central questions:

1. Does it improve the access to and maximise the quality of health care?
2. Does it minimise the cost of health care? And
3. Will it be politically and otherwise feasible and acceptable?

These question may be stated in different ways, but the issues remain the some all over the world. The available resources are limited and therefore every rupee committed to health care would mean a rupee less for other things. We just know what we would have got for very rupee that we give up. The trade-off are involved between cost of care and effectiveness (at individual and societal levels) is becoming more and more difficult to resolve over the years as advances in medical technologies take place. The importance of this critical trade-off issue lies in the fact back the out come of these decisions will determine 'Who shall live.'

There are a number of macro decisions that need to be considered while designing a health -care systems for a country. These macro decisions determine (a) what kind of health care services will exist in a society, (b) who will get them and on what basis, (c)

who will deliver them, (d) how the burden of financing them will be distributed, and (e) how the power and control of these services will be distributed. These decisions, which critically affect the level and distribution of our well-being ("the risk of our getting sick the likelihood of our being cured, and the degree to which others will help us when we become impaired or dysfunctional") involve issues of social justice. The issues of social justice are: How much of equality should there be? What inequalities in access to health care are morally acceptable? How should the burden of achieving that equality be distributed? We are yet to evolve a framework and a set of principles which may serve as a 'public and final' basis for resolving disagreements about how basic institutions, such as health care institutions, should be designed; so far, there appears to be no consensus on any set of principles to resolve the conflicting claims advanced by different groups within a society.

Some believe that an appeal to the notion of right to health care will help redesign the systems which can eliminate inequalities in the distribution and access to health care. But it should be noted that a clear distinction between right to health care and right to health is not always possible. The notion of right to health care is too broad and vague unless they are specified further. Things become a lot more complicated., when we want to express our concern for equality while talking about right to health: do we want 'equal right to health', or 'right to equal health'? The right to health includes a much broader range of actions-some of which are normally not considered as part of health services-that affect health. A right to health care could mean different things to different people, both with regard to the scope of what is being claimed and with regard to the justification it needs. In general, a right to health care may be decomposed into the following :

1. Society has the duty to its members to allocate an adequate share of its total resources to health-related needs, such as the protection of environment and the provision of medical services ;
2. Society has the duty to provide a just allocation of different types of health services, taking into account the competing claims of different types of health needs;
3. Each person is entitled to a fair share of such services.

But none of these helps (that is, asserting a right to health care does not help) us in anyway in deciding about the following policy issues:

1. What share of total resources is adequate for servicing health needs?
2. How should such a share be divided among the different types of health needs?
3. What is an individual's fair share of such health services?. This includes an answer to the question, who should pay for the services/

The right to health care is thus very vague and this does not help us settle the complex problems about how health services should be financed.

It appears as if the most important question underlying the above discussion is: 'Is health care special'? Should we view it as we view other commodities in our society so that inequalities in access to health care may prevail with inequalities in other respects; or, should we view it as 'special' because of its very specific functions and its effects in improving the quality of our life in various ways? Irrespective of the position we may take, it should be noted that the question: Is health care special/ determines the basic structure and design of a health care delivery system. As the special nature of health care continues to occupy the minds of academics and policy-makers, there is a strong view emerging all over the world that there are reasons of justice for distributing health care more equally. This has played a significant role in regulating the structure of the delivery system: these include regulations about the extent of capital investment in health care, containing cost of care through various cost-sharing and budget-capping proposals restricting the autonomy of providers, etc.

The tremendous increase in the cost of delivering health care, which is one of the direct consequences of its increasing dependence on high-technology, has posed more sharply the question of access. The purpose of public policy, both in the market and non-market economics, has always been to reduce some of the important barriers in access to care. In fact, the two most important goals, namely, (a) to have an universal access to health care and (b) to contain the cost of obtaining care, have largely guided the policies of many countries; the primary health care (PHC) model adopted at Alma conference in the late 1970s was largely guided by these two considerations. But whether or not and to what extent such policies in fact have helped achieve full or greater equality in the distribution of health care is not our main concern here. We are more concerned with asking, with does equality of access to health care mean? What can we do to promote equality of access, however it may be defined? The former is dealt with in Section II and latter in Section III.

II

The literature on access to health care is quite extensive, covering a wide range of issues, one of which is the measurement of the inequality in access to health services. It is often in the selection of criteria for the measurement of inequality that disagreement arise. What follows is a brief discussion on some measures of equality of access to health care, as proposed by Julian Le Grand, and Jones and Moony. The measures that we consider here are : (1) Equality of public expenditure; (2) Equality of cost of health care; (3) Equality of physical accessibility; (4) Equality of use (use per need); and (5) Equality of outcome. This list is certainly not exhaustive; it is possible to add a few more.

Equality of Public Expenditure

This argues that resource allocation for health care to individuals should be made on per capita basis This will result in allocation of the available resources to the members of the society in equal proportion. The weakness of this apparently just approach is that different individuals may have different health care needs and therefore equality of public expenditure may in reality be inequality . There may be no consistent bias or a pattern of disadvantages against any particular class, but if its health care needs are taken into account (say, based on the reported level of illness of the individuals), they ought to have been.

Equality of Cost of Health Care

This argues that the cost of obtaining a health service should be the same for all the individuals. While it establishes equality in terms of cost of care, it clearly ignores the principle of ability to pay. In fact, much of our confusion about equality of care arises because not all members of a society belong to the same economic class and have the same purchasing power. Financial barriers lie at the centre of our discussion about equality. Individuals belonging to different economic classes but with equal need for a particular health care service would suffer from unequal access to it if the cost of obtaining it is the same for all . So obtaining equality of cost indeed will result in inequality of opportunity to access.

Equality of Physical Accessibility

The role of space in defining equality of access is very important, as the distance an individual has to travel to reach a health care facility has a direct bearing on the extent to which he/she will use it. Some studies have shown that the use of health services is a direct consequence of proximity to those resources. In essence, one may say that there is a "distance decay in the number of patients registered with a particular doctor with distance from the doctor's surgery". Travelling a long distance to make use of a health care facility will affect the actual use of it, for it involves loss of time, effort and money. This deficiency may be remedied by recognising the social groups for whom distance is a major barrier to access and locating the facilities in discrete positions, Measuring inequality of access using physical accessibility is very useful for micro-level understanding of the prevailing conditions. The trouble with this measure is that it may not cater adequately for the regional need. In a sense, it is similar to the notion of equality of per capita expenditure: just as it does not in general satisfy the needs of different individuals, the equality of physical accessibility too does not in general cater to the needs of a region. It may be that a region well provided for (relatively speaking) might in fact need more resources to meet the required level of care.

Equality of Use

Another view is that there should be equality of opportunity to use according to the needs. Various attempts have been made to infer this from measuring 'equality of utilisation per need². This is an important criterion, perhaps the most appealing of all mentioned so far, since it demands that individuals will have access to health care whenever there is a medical need. In effect, it states that only health status should determine access to health care-equal treatment for equal need. But we know that there are several factors other than health status that have an effect on the use of health care, and therefore we require a way of testing which of these other factors actually do have a significant effect on access (measured in terms of actual use). These other factors may be termed potential access factors: some of them are related to the structural features of the health care system, such as the availability of physicians, hospital beds, patient-doctor ratio, distance etc., and some of them reflect the 'predisposing and enabling' features of the individuals in the population, such as age, social and cultural background, income and insurance coverage level, etc., All these play an important role in determining the level of access to health care achieved by an individual. Our task is to understand and explain how much of the variations in actual use of health care is due to need and how much due to potential access factors. If our policy is to allow access to health care based on need alone, then we must eliminate all of barriers arising from the potential access factors which produce intergroup variations on realised access (utilisation rates). If a

potential access variable, say waiting time for an appointment (sometimes also called a process variable in the literature), is found to have no effect on utilisation rates for population subgroups, then it is not casually significant according to the criterion being proposed. The test of equality of opportunity to use is the actual use, it may be claimed, because, "the proof of the pudding is in the eating".

But we must be careful about this logic. It is true that measuring equality of access as use per need has certain relative advantages over the others. But there can also be several objections to using such a measure (a) variations in potential access factors can have serious equality implications even if they don't show up in utilisation rate. Time spent in the waiting room, or the money spent out-of-pocket may not affect the utilisation rates, but may have a significant effect on the satisfaction with care. Equal utilisation per need does not necessarily mean equal efficacy of the services delivered. The quality of services might vary, though use per need is similar. The issue is also closely linked to the patients' perception of quality of care received by them; (b) It is therefore arguable that "uniformity between subgroups in utilisation rates (use per need) is not even a necessary condition for equitable access". For example, some subgroup variations might be explained by differences in attitudes toward health care. One can give several examples in this respect. One might underuse a health care facility simply because one is averse to it on some moral or philosophic grounds. There may be some religious and aesthetic reasons as well for not using a service. It may be due to ignorance, or due to informed (principled) choice. Perceived subjective needs (i.e. one's perception of when one is in need of medical care) play an important role in seeking health care. So, clearly the 'equality of use' approach leaves much room for modification. Equality of access must ensure equality of quality of care. This condition is perhaps the most difficult to ensure and none of the above measures can capture this aspect adequately. In fact, as we shall see below, the quality of care (as felt and realized by the patients) has now become an important one in evaluating the effectiveness of medical services.

Equality of Health Outcome

The measures that we have discussed so far are concerned with equalisation in the provision of health resources. Equality of outcome attempts to measure the outcomes of such provisions of health care, rather than merely on the amount spent on the various sections of the society. To the extent there is equality in health, it may be argued, we may say that equality of access has been achieved. This is closely a kin to the issue of right to equal health, referred to in Section I. This is a much larger issue. We may measure the outcomes of health care provision, say in terms of age-specific death rates, life expectancies, and so on and compare them across various populations. But such

comparisons do not recognise the genetic, cultural and other exogenous factors that have a bearing on the health of the people. We do not have a neutral definition of health that can be applied to individuals from diverse cultural and social backgrounds. Some individuals may not desire, for example, the same years of life, or may (in fact, do) view illness differently. The definition of good health is perhaps the most vexing and frustrating of all issues. In fact, a new movement is taking place in redefining 'outcomes' of medical interventions. Traditionally, safety and efficacy of medical treatments were measured using clinical, physiological and biomedical indexes. Now the range of outcomes has been expanded to include the following: functional status, emotional health, social interaction, cognitive function, degree of disability and so on. The information on these can be obtained only with the help of patients which will be subjective. Although these are still imperfect measures, it is hoped that they will greatly enable the providers. The employers, the policy-makers and other concerned parties (like insurance companies) in evaluating more rigorously the effectiveness of outcomes of medical services. Understanding how different interventions affect ('such factors as physical and emotional function, social activity, and return to work') will provide a more sensitive gauge of the effectiveness of interventions. Providing such information decisions". The point made here is that use of traditional measures of outcomes to infer the level of access to health care highly inadequate and is not more considered satisfactory in evaluating effectiveness of medical services. Therefore, such measures cannot adequately reflect the quality of access to health care achieved.

III

When is then access to health care equal? And how do we measure it? Each of the above-mentioned measures of equality of access fails on many grounds, particularly in meeting 'needs'. The identification and measurement of need is central to the promotion of equality of access. It appears that neither equity nor need can be defined precisely. To what extent each of the measures discussed above answers the two interrelated questions, access to whom and access to what? Should we allow universal access to all forms of available and validated health care services or only to select health services? The issue is one of achieving a balance between horizontal and vertical equity. The discussion invariably leads us to defining health care needs, and still further, to questioning whether each of such needs (however they may have been estimated) should necessarily be fulfilled. There is in fact yet another deeper problem in the whole exercise, namely, the presumption in all our discussions that for every medical need there exist a remedy, even though often there is none.

It appears that it is impossible to define basic health care needs, strictly speaking, for all the individuals in the society. It varies from region to region and from decade to

decade, because our capabilities develop with changing technologies and knowledge-base. Yet at any given point of time we are forced to set our priorities, and decide who shall get what and how much. Every country in the world at present has been attempting to define its basic health care needs, which boils down to prioritising the various health care programmes and each one of them has been experimenting with a combination of different mechanisms for delivering health care to achieve equality in health care provisions. Some countries have largely relied on market forces to deliver health care, some have chosen to deliver solely through public funds, and there are some other countries which have adopted a combination of these two methods to different degrees. But whatever be the mechanisms adopted or been experimenting with, there has been increasing evidence of widening disparity in access to health care across various social classes.