Addressing Inequities in Healthcare Coverage

Rationale

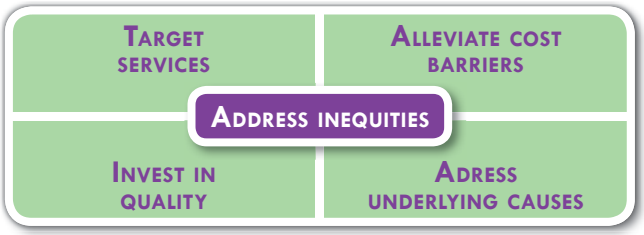
The burden of mortality and ill-health is carried by the most vulnerable and hardest-to reach women and children: the poorest, those living with HIV/AIDS, orphans, indigenous populations and those living far from health services. Socio-cultural, religious, economic, political and geographical factors all contribute to women and children having the poorest health outcomes and the most difficulty accessing services. RMNCH coverage indicators (e.g. skilled birth attendant coverage and full antenatal care) often serve to highlight country-level inequities in both access and outcomes by the poorest and most vulnerable women and children. Addressing inequities in maternal and child health is a key strategy to improve health and survival and requires the removal of avoidable and unfair differences in healthcare through strong advocacy and action at global, national and local levels.

Getting started

Carry out an evidence-based assessment of the coverage of RMNCH services, and disaggregate the data using health equity analysis tools to determine whether the most vulnerable groups are benefiting (see Toolbox). Conduct research into the social determinants of poor health and inequity and prioritize those factors that contribute most to inequitable service coverage, utilization and RMNCH outcomes. Adapt policy and program options for addressing inequities to local needs. Set in place and implement an equity-sensitive monitoring system. Assess institutions and programs already working on RMNCH equity, as well as broader health and non-health sector equity issues, to identify points at which to improve alignment, collaboration and integration.

UN Photo/Evan Schneider

Approaches



1. Promote health equity and target services

- Promote health equity as a shared goal for all partners and make universal, equitable access a central component of health systems.
- Target specific groups of women and children, where appropriate, by poverty level, geographical location, type of population and other factors that characterize vulnerable populations. Deploy RMNCH services and health workers to these targeted groups and geographic areas.

2. Alleviate cost barriers

- Abolish user fees for essential health services, so services for women and children are free. If not financially viable to eliminate fees across the health system, at least do so on a targeted basis, such as for facilities at the primary health level or facilities in rural areas.
- Expand coverage to the poor in national/social health insurance programs (see summary on *Financing Access to RMNCH Interventions for Universal Health Coverage*).
- Establish a cash transfer system – conditional or unconditional – to support poor women's and children's access to transport or loss of income incurred seeking care. If conditional, carefully assess the recipient population to understand basic barriers to care and to establish realistic compliance targets, useful structures of reimbursement and potential non-health sector partnerships (e.g. transport vouchers to bus companies).
- Implement voucher programs for vulnerable groups that entitle the bearer to obtain free or heavily subsidized RMNCH-related goods or services from a contracted provider.

3. Invest in quality health service provision

- Extend the network of health facilities, particularly in rural areas, to create equitable coverage to the most vulnerable populations. Within this network, invest in human resources and ensure the availability of RMNCH commodities.
- Strengthen health service provision at the household- and community-level to spare poor women and children the direct and indirect cost of seeking care. Promote task shifting to increase coverage and equity of access to care in underserved communities. Extend training,

support and supervision to community health workers and birth attendants.

- Adopt national policies on quality assurance of health providers and services (e.g. quality standards, credentialing of health workers and accreditation of health facilities) with an emphasis on ensuring poor people have equal access to quality care.

4. Address underlying causes of inequity

- Take cross-sectional action to address the social factors that underlie patterns of inequity. Invest in policies and programs in other sectors including education, infrastructure development, water supply, sanitation and income generation.
- Advocate for legal protection against discriminatory gender- and age-based norms and practices and sensitise communities to their negative consequences. Empower women and children through rights-based information, education and communication campaigns, including health messaging. Strengthen accountability systems to enforce anti-discrimination policies. Support civil society organizations, Advocate for gender equality and an end to gender- or age-based violence.

Role of actors

This summary may be of use to members of local and national governments, global and national policy-makers, and health professionals. Collaboration amongst health and non-health sectors (such as education and gender) is essential for addressing inequities.

Toolkit

APPROACH	RESOURCES
Health equity analysis	▪ Countdown to 2015 for maternal, newborn, and child survival. www.countdown2015mnch.org ▪ World Bank's *Health Equity and Financial Protection* website. web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPAH/0,,menuPK:400482~pagePK:149018~piPK:149093~theSitePK:400476,00.html
Abolish user fees	▪ UNICEF (2009). *Removing User Fees in the Health Sector in Low-Income Countries: A Multi-Country Review.* www.itg.be/itg/Uploads/Volksgezondheid/unicef/UNICEF_Multi-Country_review.pdf
Cash transfers and vouchers	▪ Samuels F, Jones N (2011). *Cash transfers for maternal health: design opportunities and challenges in low-resource settings*. London: ODI. www.odi.org.uk/resources/details.asp?id=6186&title=cash-transfers-maternal-health-project-design ▪ Results-based financing for health. www.rbfhealth.org/rbfhealth/
Task shifting	▪ Global Health Worker Alliance *Task Shifting* website. www.who.int/workforcealliance/knowledge/themes/taskshifting/en/index.html
Address underlying causes of inequity	▪ Commission on Social Determinants of Health, 2005-2008. www.who.int/social_determinants/thecommission/en/ ▪ Urban Health Equity Assessment and Response Tool. www.who.int/kobe?centre/measuring/urbanheart/en/index.html

Case study

Since independence in 1948, the government of Sri Lanka has prioritised primary health care (including maternal and child health) through strengthening its rural health network. Communities' close physical access to facilities has been key to reducing mortality rates and achieving continuous improvement in health indicators for poor women and children. The concept of universalism is central to health care provision in Sri Lanka and access to health services is seen as a fundamental social right. Government health services are free for most inpatient, outpatient and community-health services, while family planning commodities are provided in the public sector at a low cost. Midwives are professionalized and receive ongoing supervision and training. Sri Lanka has had a good civil registration system since 1867 and this and other data have been used systematically to identify problems and guide decision-making. Equity analysis shows that government health expenditures have reached the poor effectively since the 1950s. Sri Lanka has been able to achieve health service access similar to OECD economies while spending much less than most countries at similar income levels.

Sources: Levine R. "Case 6: Saving Mothers' Lives in Sri Lanka." In Millions Saved: Proven Successes in Global Health, Center for Global Development, Washington DC, 2004; Rannan-Eliya RP, Sikurajapathy L. Sri Lanka: "Good Practice" in Expanding Health Care Coverage, Institute for Health Policy, Colombo, Sri Lanka, 2009.

Opportunities to engage

- Partner with the Countdown to 2015 for maternal, newborn and child survival (www.countdown2015mnch.org). Countdown to 2015 tracks country and global progress towards achievement of MDG 4 (child mortality) and MDG 5 (maternal health), including assessments of inequities. Partners can work with the Countdown to utilize data and methodological approaches at the national level.
- Utilise research findings from Equity in Asia-Pacific Health Systems, or Equitap (www.equitap.org). Equitap is a network of research groups in the Asia-Pacific region that examines health equity issues to inform the development of more equitable health systems in the region.

Resources

- Child Survival Call to Action (2012). *Summary Roadmap.* 5thbday.usaid.gov/pages/ResponseSub/roadmap.pdf
- Countdown to 2015 (2012). *Equity Analyses and Profiles.* http://www.countdown2015mnch.org/reports-and-articles/equity
- International Society of Equity in Health (ISEqH) and its peer reviewed, electronic journal *International Journal for Equity in Health.* www.equityhealthj.com
- PMNCH (2010). *Knowledge Summary 9: Address Inequities.* http://portal.pmnch.org/knowledge-summaries/ks9
- UNICEF (2010). *Progress for Children: Achieving the MDGs with Equity.* www.unicef.org/publications/index_55740.html
- Yazbeck AS. (2009). *Attacking Inequality in the Health Sector: A Synthesis of Evidence and Tools.* World Bank, Washington DC. www.who.int/pmnch/topics/economics/2009_yazbeck/en/index.html

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