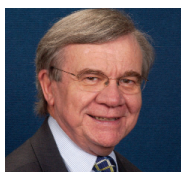


# Equitable access: good intentions are not enough



Article by Robert Wells (pictured) and Judith Whitworth

Most countries do not have universal health insurance and for most people living in countries without universal access, particularly the poor, illness is a substantial financial burden, and indeed often a crippling burden. Paradoxically, a far greater proportion of out-of-pocket spending occurs in those countries least able to afford it. Inevitably, health care, far from being a basic human right, is simply beyond the reach of many.

As a proportion of gross domestic product (GDP), developed countries spend around 8–9% on health (this includes both government and private spending)<sup>1</sup>. In contrast, in lower- and middle-income countries' proportional expenditure is usually far less, e.g. Sri Lanka spent 1.3% and India 0.9% of GDP in 2004<sup>2</sup>. In Ghana per capita spending on health was estimated as US\$ 8 per person per year in 2004<sup>2</sup>. This contrasts with the United States figure of around US\$ 6100 in 2004. The Macroeconomic Commission on Health considered US\$ 30–40 as the minimum necessary for basic health interventions<sup>2</sup>. These figures reflect in part relative wealth of countries, but clearly also are dependent on spending priorities of governments. Thus in many countries basic health interventions for all are not assured.

Some countries, most particularly wealthier countries, have schemes/systems for universal health insurance e.g. Australia, UK, many European countries. Ironically the world's richest nation, the USA, stands out both as not having a system of universal health and as spending absolutely and proportionally much more on health than any other country. Developed countries with comprehensive universal health insurance tend to spend less on health than those without such systems such as the USA<sup>1</sup> or with more limited universal coverage (such as Canada and Australia), although health outcomes are equivalent or better, pointing out the desirability of universal access. The USA spends nearly twice as much as the UK without any comparable improvement in health outcomes, and it has been estimated that at least some premature mortality in the USA represents inadequate access<sup>3</sup>.

Universal access is generally regarded as a highly desirable policy. Yet even in this context, there are often inequities, which may not be intended. For example, in Australia factors which inhibit access and introduce inequity include uneven geographic distribution of health services; unequal capacity to afford "out-of-pocket" expenses (such as patient co-

payments, travel, or time off work); the limited range of available services e.g., shortages in some speciality areas such as geriatrics, ophthalmology; the global problem of insufficient workforce which particularly affects rural Australia; and long waiting times for high demand services, which can be bypassed by the rich (via the private sector) but not by the poor.

These problems are magnified in lower- and middle-income countries, for example, in Tanzania a 1997 scheme to implement evidence based health plans at an estimated cost of US\$ 2 per capita was limited by inadequacy of infrastructure and capacity<sup>4</sup>. These difficulties have been widely recognized and are seen in particular where increased spending on vertical programmes in areas of limited capacity and infrastructure have led to redirection and further weakening of resources available to the system as a whole.

There are further difficult questions around our understanding of what is equitable. For example, Australia spends around 1.5 times more per head on health care for its indigenous population than for non-indigenous people. However, the health status of indigenous people is appalling; with life expectancy almost 20 years lower than for the non-indigenous population. If expenditure is considered in terms of disease burden then indigenous health is significantly under-funded. Indigenous people living in remote areas have 10–20 times higher death rates than non-indigenous Australians from diseases such as diabetes, cervical cancer, respiratory disease and infections<sup>5</sup>. Suggestions for the additional spending required to improve health status for indigenous people range from two to three times that for non-indigenous people but these figures seem to have no firm basis and therefore would provide no guarantee of achieving a measurable improvement. There would probably be a need also for a concomitant proportional increase on social and infrastructure support spending for indigenous people.

## The research agenda

What then are the research questions around equitable access? How long is a piece of string?

For example:

1. What do we mean by equity? Which aspect has primacy – dollars spent or health status or health outcomes?
2. How do we determine what is a reasonable amount to spend (or invest)? How can this best be contextualized and

harmonized with other government priorities? This is even more problematic when we consider that other areas of government spending e.g. education, housing, transport, may all impact on health in major ways.

3. Would there be more equitable access to health services if governance and decision-making were more open to input by community stakeholders? Another aspect of this question of governance is: how can governments reasonably reorder priorities given the range of pressures on their available resources?
4. Given the resource and other infrastructure constraints, particularly in poorer countries, what are the most appropriate health care delivery models for a country to adopt?

Given this possible research agenda, are these questions capable of analysis that is likely to lead to useful outcomes? Are they universal or is the specific context of local country considerations so dominant that no general conclusions can be drawn? Is there political will to address this agenda, let alone tackle the problems on the ground?

The first question, what is equity?, seems capable of answer, albeit not in a generalizable way. What people mean and want by equity could be established in specific contexts using focus groups and standard social research methodologies, for each level of government and decision-making. If people see equity of outcome as having primacy, then simple equity around allocation will not be enough. Nevertheless, unless there is some broad agreement on the answer to this question for a given society, allocation of resources and planning of services is much more difficult.

The second question, what is a reasonable amount to invest in health? is more difficult. However data are or will be available on how much countries spend and on return on investment as determined by health metrics, status and outcomes. The new institute for global health evaluations, the Gates Foundation funded Health Metrics and Evaluation Institute at the University of Washington in Seattle should fill a critical gap by providing better information on health metrics and health system performance<sup>6</sup>. These will include data on mortality, cause of death, disease and disability burden, risk factors, resource flows and assessments of health systems<sup>6</sup>. We know that above a certain level of spending, health improvements are not evident, e.g. USA. Cuba on the other hand has excellent outcomes for modest spending. However, below a certain level of spending, health status is poor and this is reflected in poor health outcomes for the poorest countries. It may be useful to compare country performance for like countries as a guide to allocative efficiency in a particular context. Analogous with the Australian indigenous situation, some focus on health outcomes would seem desirable particularly where there are varying local ethnic, cultural, social or geographical factors.

The third set of questions address governance and how actual spending priorities are determined and set. Again, social and cultural factors have primacy here, both in the process for decision-making and in determining the particular value sets for identifying and respecting priorities. Some

principles that might guide governance could include measurement of what is done and evaluation of what is achieved, along with openness and transparency of decision making, and a long-term commitment to agreed plans and their implementation.

The fourth question is very important in providing capacity to move forward within the constraints of available resources and competing priorities. For many countries a high technology health system is an unrealistic expectation even for the longer term. The priority will be in dealing with basic health needs and public health measures. Mullan and Frehywot suggest, for example, that the use of non-physician clinicians in sub-Saharan Africa might be an effective means of meeting some of the workforce demands to meet current and future demand<sup>7</sup>.

For many countries, the governance will be a key factor in providing some stability and at least medium-term certainty to the health system. Developing and sustaining a health system is a long-term challenge. The provision of basic health infrastructure and capacity, including access to the routine services and checks that help in maintaining good health and detecting emerging health problems for the population at large, is often well beyond the political horizon. Tackling urgent problems can often be undertaken at their expense. The temptation can often be to focus on one or two high-profile health problems or diseases or skew resource allocation in these areas. A robust governance system should allow these storms to be weathered without abandoning the whole ship.

This balancing of long-term sustainability against short-term crisis can be the hardest challenge for any health system.

The experience of all countries, rich or poor, is that there is an insatiable demand for health services. Achieving equity of health status depends on a range of factors, individual, environmental and political and not simply the nature of the health system, not the quantum of available resource. There are some important questions which need to be addressed to assist countries or regions in deciding how best to determine how much they might invest in health and how this investment might be made. Most important of all is political will. Decisions about health are made, often unintentionally, in policies around finance, education, defence, agriculture, transport, housing and so on, as much as they are by decisions within the health system. Perhaps we should rephrase our debates. Just as we have moved from thinking of health research to thinking of research for health, we should think of investment for health rather than investment in health. □

*Robert Wells is Co-Director of the Menzies Centre for Health Policy and Executive Director of the College of Medicine and Health Sciences at the Australian National University, Canberra. He works on a range of health policy and systems issues, including primary care, private health insurance, rural health and health workforce. He has participated in national advisory committees on neurosciences research and attracting greater private sector investment in health and medical research. Robert has had many*

years' experience as a senior administrator in areas such as research, Commonwealth/State relations, health workforce, safety and quality and management of the programmes for better management of major diseases such as cancer, diabetes and mental health and rural health programmes.

**Judith Whitworth** is the Director of the John Curtin School of Medical Research, and Howard Florey Professor of Medical

Research at the Australian National University in Canberra. Professor Whitworth has practised medicine and researched extensively in Australia and overseas; she chaired the Medical Research Committee of the National Health and Medical Research Council of Australia. She is chair of the WHO Global Advisory Committee on Health Research (2004–2007) and a member of the Foundation Council of the Global Forum for Health Research.

## References

- <sup>1</sup> OECD in *Figures 2006–07, Health Spending and Resources*. OECD, Paris, June 2006
- <sup>2</sup> Evans T. Arguing the case for strengthening health systems. *Bulletin of the World Health Organization* 2004, 82:956-8.
- <sup>3</sup> McGinnes JM, Foege WH. Actual causes of death in the United States. *JAMA* 1993; 270:2207-12.
- <sup>4</sup> TEHIP and Tanzania's Health Reforms. International Development Research Centre (IDRC) Canada, 2002. [http://www.idrc.ca/en/ev-6236-201-1-DO\\_TOPIC.html](http://www.idrc.ca/en/ev-6236-201-1-DO_TOPIC.html)
- <sup>5</sup> Mooney GH, Wiseman VL, Jan S. How much should we be spending on health services for Aboriginal and Torres Strait Islander people? *Medical Journal of Australia* 1998, 169:508-9.
- <sup>6</sup> Editorial. A new institute for global health evaluations. *The Lancet*, 2007, 369:1902.
- <sup>7</sup> Mullan F, Frehywot S. Non-physician clinicians in 47 sub-Saharan African countries. *The Lancet*, published online, 14 June 2007. <http://www.thelancet.com>