Access to Health Services in the World

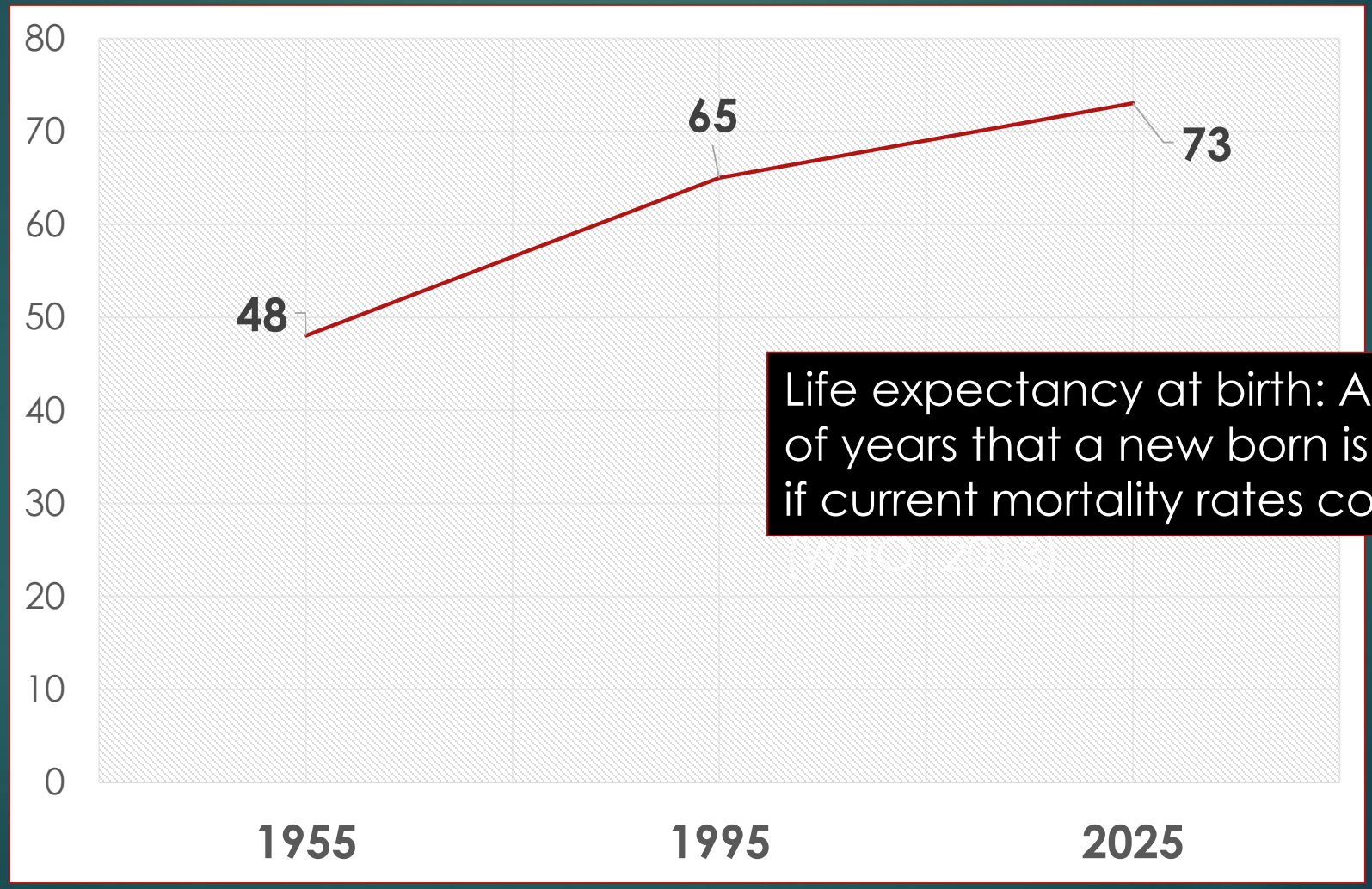
Standing Committee
for Economic and Commercial Cooperation
of the Organization of Islamic Cooperation (COMCEC)

13th Meeting of the COMCEC Poverty Alleviation Group,
Ankara, 4 April 2019

Presentation: Part 1

IDS Institute of Development Studies

We now live longer…



Life expectancy at birth: Average number of years that a new born is expected to live if current mortality rates continue to apply

Figure: Trend in global life expectancy at birth (years) (WHO, 2013).

But we live in an unequal world…

- In 2015, 22 countries in the world (all in Europe, Americas and Western Pacific regions) had a life expectancy equal or higher than 80 years whereas 22 countries – all in Sub-Sharan Africa - had a life expectancy lower than 60 years.

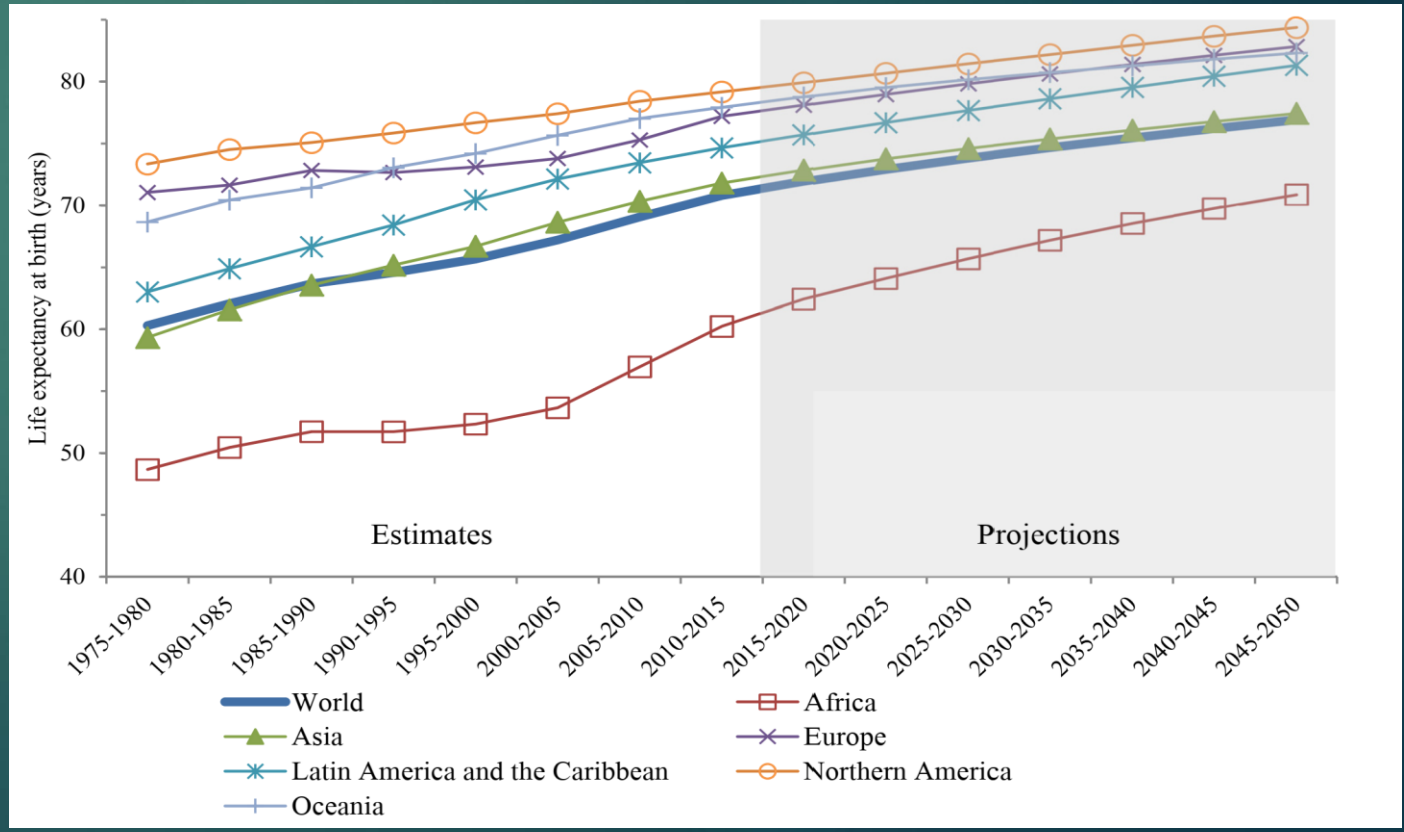


Figure: Life expectancy at birth (years) by region: estimates 1975-2015 and projection 2015-2050) (DESA, 2017).

Health and Development Are Intimately Related…

- Health is one of the basis of social justice
- Health is a human right
  - WHO 1946: highest attainable standard of health is a fundamental human right
  - UN General Assembly in Paris on December 10, 1948; article 25 (1)

Note: From operational viewpoint this requires multidisciplinary approach and acknowledgement of the relationship between various socio-demographic and economic factors and hand

Health and Development Are Intimately Related… (cont'd)

- Good health and economic prosperity are mutually related; poor people have poor health outcome which further contribute to poverty

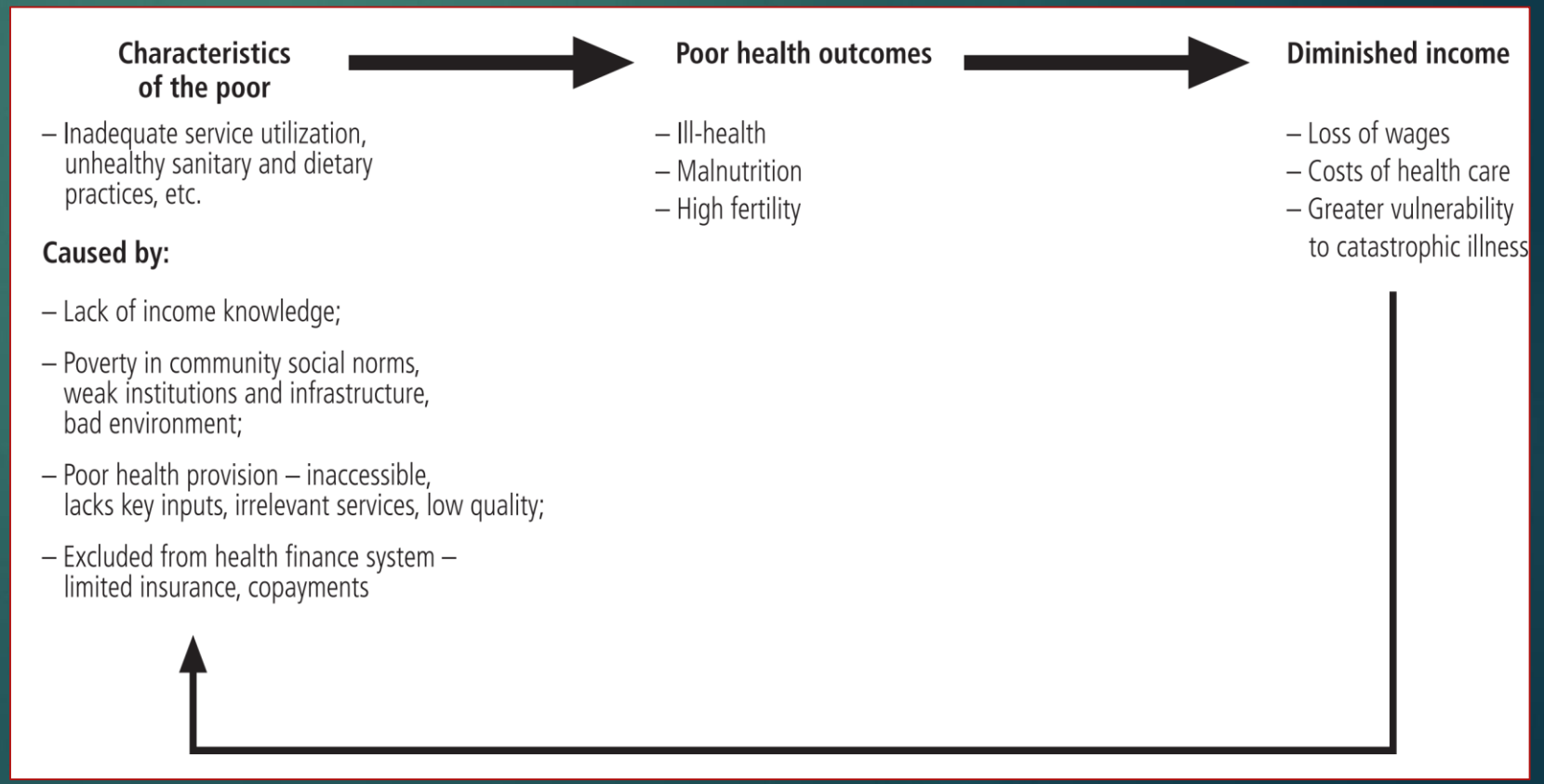


Figure: Health and poverty cycle (Wagstaff 2002).

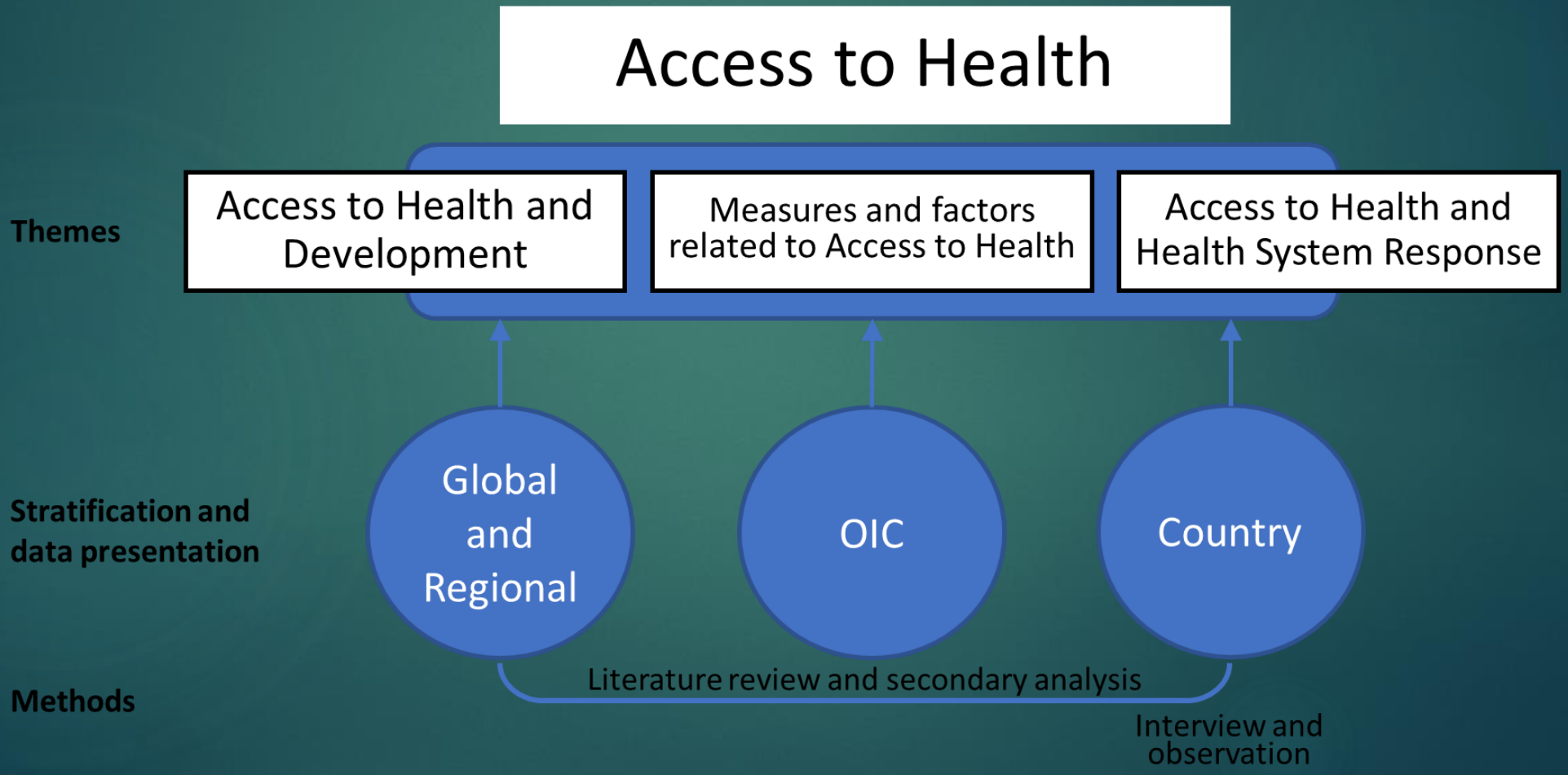
Disparity in Health; Who Are Vulnerable?

- The Commission on Social Determinants of Health (CSDH) has described health equity as, "*the absence of unfair and avoidable or remediable differences in health among social groups (Solar 2007).*"
  - lens of social determinants i.e. gender, socio-economic status, level of education, geographic location etc. (Bloom 2000, Braveman and Gruskin 2003, Davies et al. 2014, Evans et al. 2001).

Aim and Objectives

- What is the current thinking around access to health for the poor?
- What is the general situation in OIC member countries and non-OIC member countries in terms of access to health services?
- What are the levels of trends of access to health for the poor in OIC countries?
- How to organise health systems to enhance access to health for the poor? What policies have the most potential to improve access to health for the poor in OIC countries?

Method Overview



Access to Health:
Concepts, Dimensions and Framework

Access to Health: Concepts, Dimensions and Measurements

- Access to Health is the ability to ensure a set of healthcare services, at a specified level of quality, subject to personal convenience and cost, based on specified amount of information" (Oliver & Mossialos, 2004, p. 656)
- Core of access to health a) availability, b) cost (financial affordability), c) geographical accessibility and d) acceptability of health services

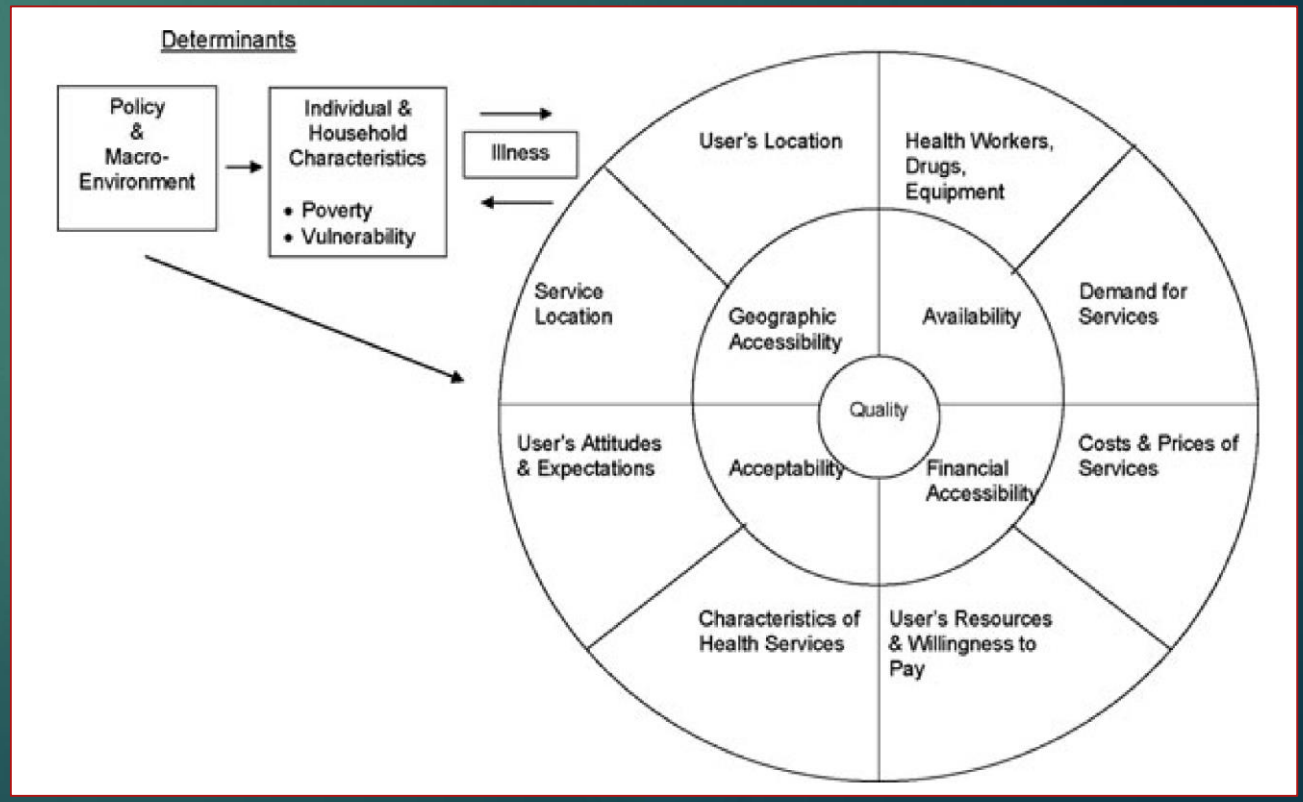


Figure: Conceptual framework for assessing access to health services (Peters et al., 2008).

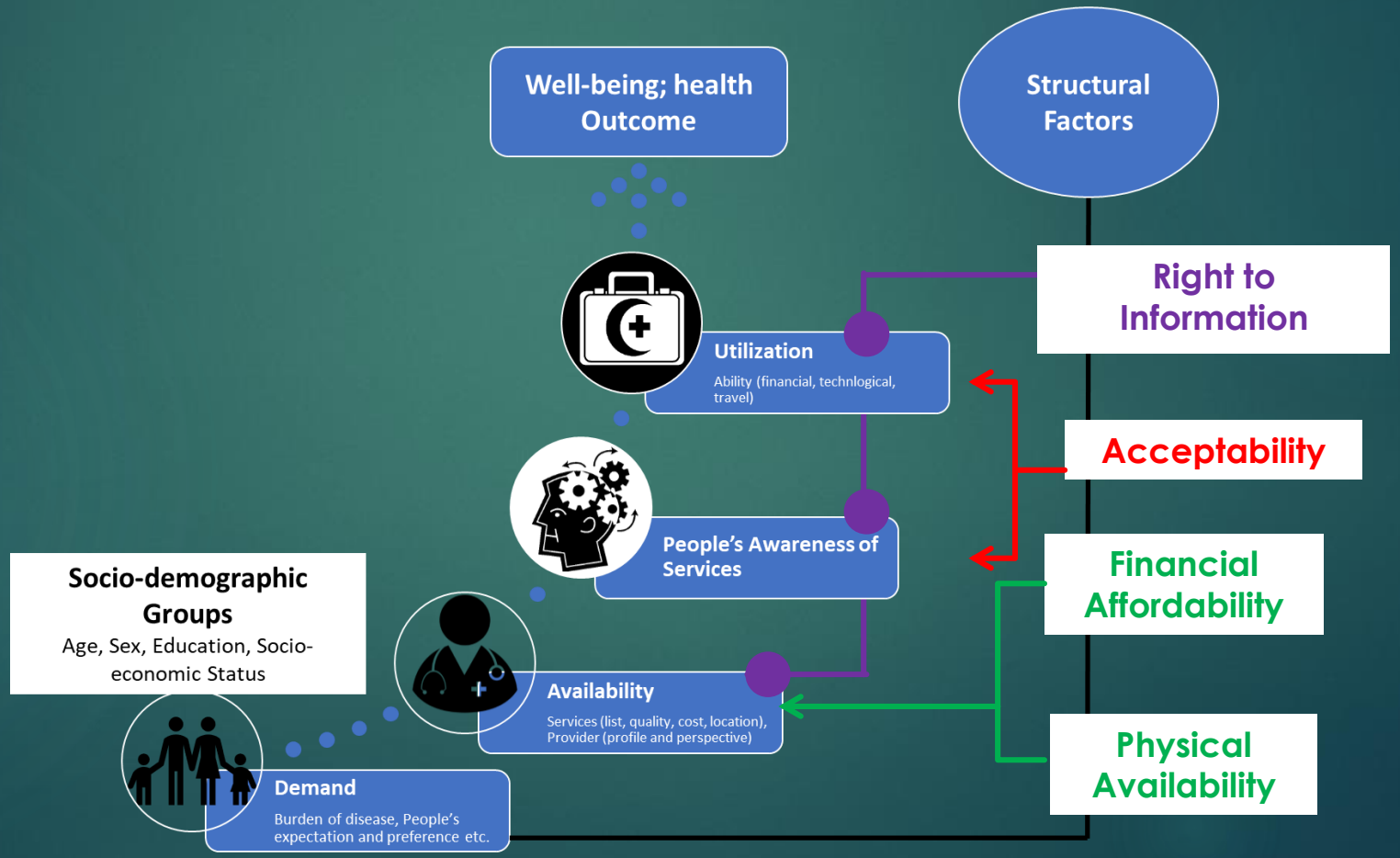
Access to Health: Concepts, Dimensions and Measurements (Cont'd)

Considering the changing context and rapid growth of technology, the dimensions of access to health is now considered as (Evans, Hsu, & Boerma 2013; WHO, 2015):

- Physical accessibility (good services are within reasonable reach of everybody)
- Financial affordability (people's ability to pay without financial hardship)
- Acceptability (people's willingness to seek services)
- Information accessibility was later added to this framework. It is the right of the people to seek, receive and contribute health related information.

Access to Health: Concepts, Dimensions and Measurements (Cont'd)

Proposed conceptual framework to assess to health by the poor:



Access to Health; Global Disparities

- In 2015, around 400 million lacked access to health; 6% of whom from LMIC slide into extreme poverty (World Bank & WHO, 2015).
- Access to health care has increased since 2000, globally but the rate of increase is unequal (GBD 2016 Healthcare Access and Quality Collaborators et al., 2018).
  - Wealthy has more access to health than poor
  - Developing countries carry 99% burden of annual maternal deaths,
  - In 2013, 98 per cent of births were attended by a skilled healthcare professional in Europe, compared to 51 per cent and 68 per cent in Africa and South-East Asia, respectively (WHO, 2015, pp. 90–91).

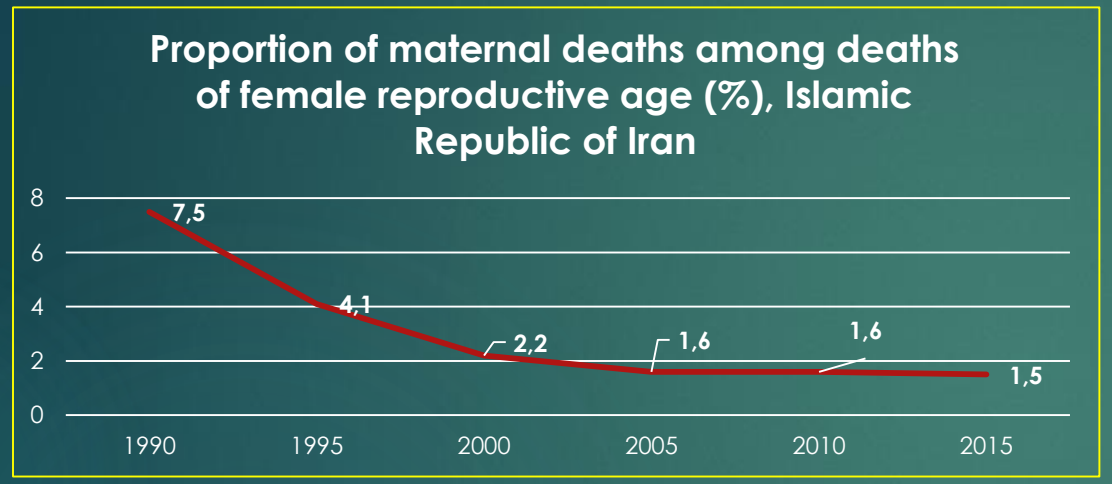
Access to Health; Global Disparities (cont'd)

- Under 5 Children are one of the main victims of health disparity (WHO, 2017):
  - Children from poorest wealth quintile are twice likely to die by the age of 5 years compared to the richest quintile
  - Africa have 14 times higher under 5 mortality rate compared to the rest of the world
- Women have higher disease vulnerability due to socio-cultural attribute (gender discrimination) and biological factors and have less access to healthcare compared to men
- And the list goes on…

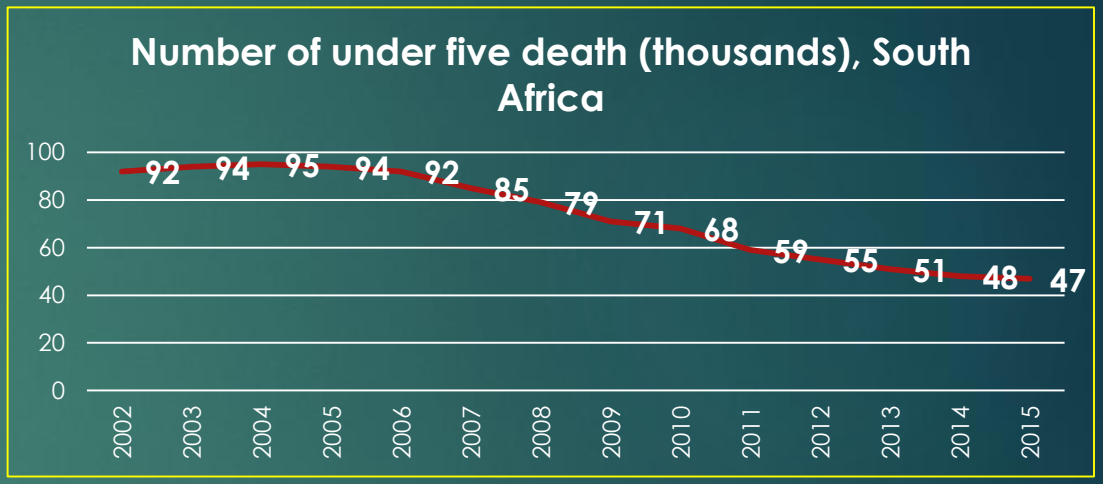
Access to Health; Global Response Towards Health Disparity

- Millennium Development Goals (MDG): reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases
  - Impressive global decline in U5MR; 93.2 to 39.1 deaths per 1,000 live births
  - Maternal mortality ratio declined by about 45 per cent since 1990
  - New HIV infections dropped by 40 per cent between 2000 and 2013
  - >6.3 million malaria deaths were prevented between 2000 and 2015
  - 54% of TB case detection and 86% treatment success rate between 2000 and 2013

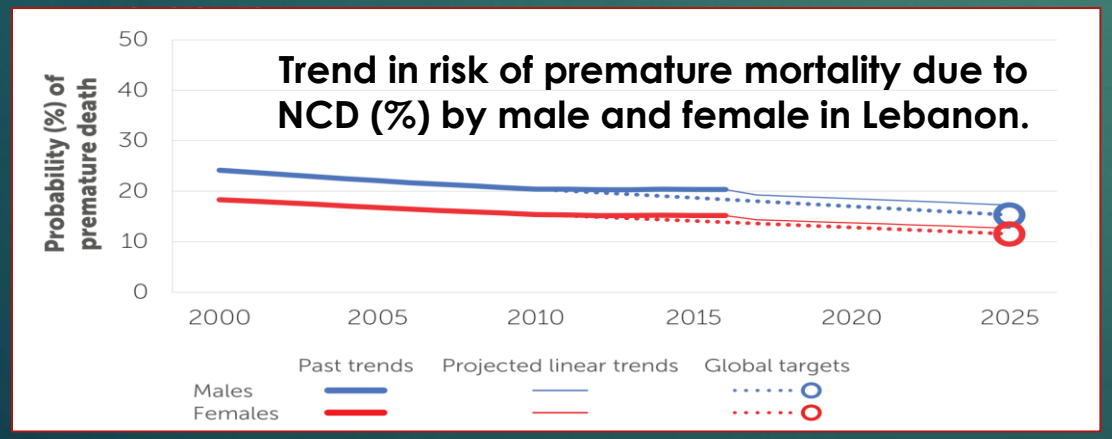
Intervention to Improve Access to Health; What Works



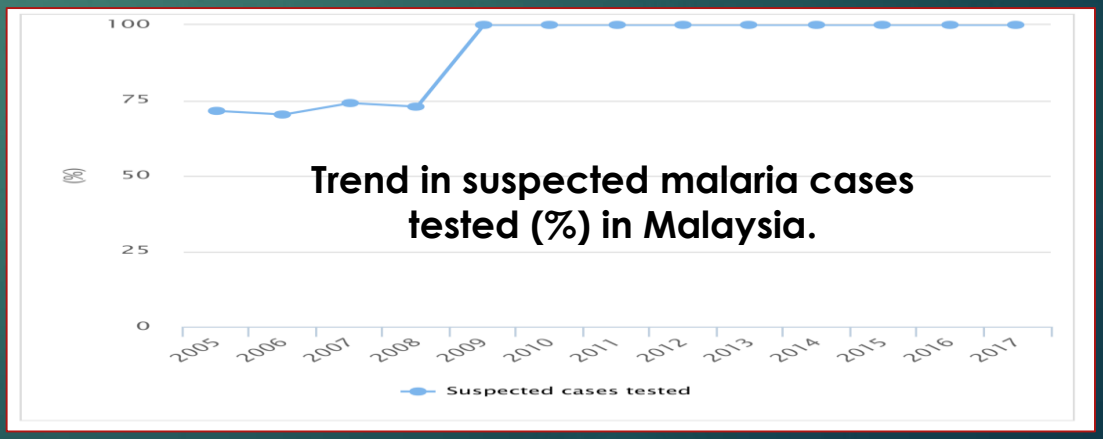
Investing into small or medium scale



Using more and more evidence (data)



Ensure intensive participation of all stakeholders



Ensure intensive participation of all stakeholders

Intervention to Improve Access to Health; What Works (cont'd)

- Major barriers to access to health related initiatives:
  - Philosophical; is the system motivated enough to secure the health right of the vulnerable and marginalized?
  - Organic; more supply side in nature; accountability of the service providers and their willingness to provide services to the poor
- Addressing these barriers requires favourable macro environment and sequential multidisciplinary efforts…

Current Level of Access to Health Services and its trends in the OIC Member Countries

- Trend over last 20 years
- Source: World Bank Health Data (November 2018) including UNICEF, various UN agencies, DHS/MICS, and may include World Bank staff estimates

Access to Health; OIC and Non OIC countries

Sample

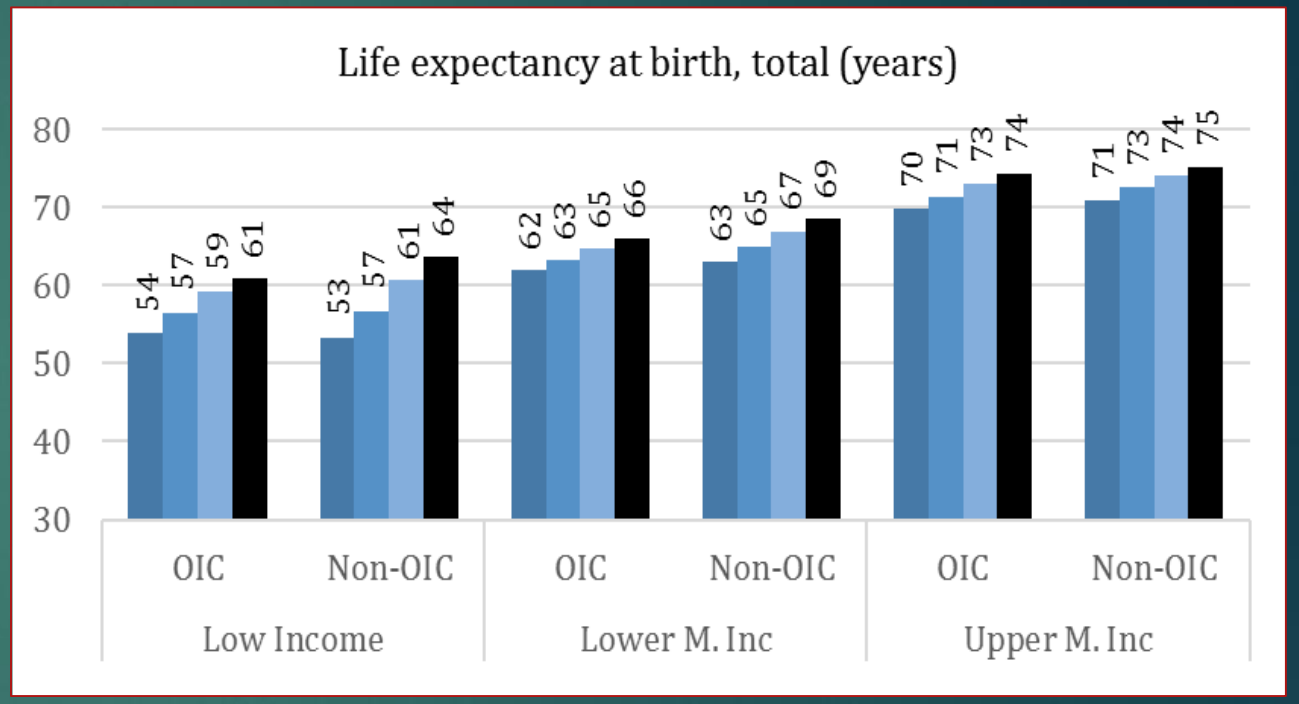
	World Bank income groups				
	High	Upper middle	Lower middle	Low	Total
OIC	7	16	15	19	57
Non-OIC	73	40	32	15	160

Source: authors' calculations

Access to Health; Health Status in OIC and Non OIC countries

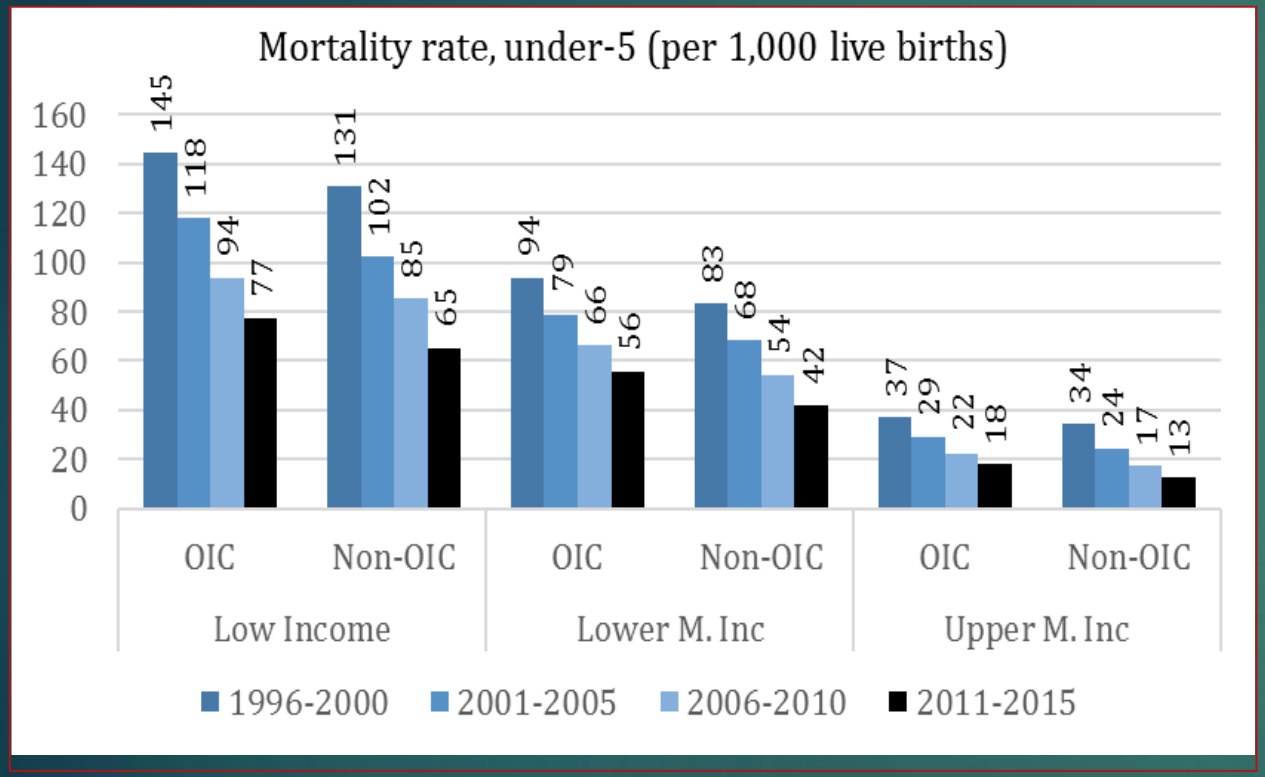
Life Expectancy at Birth

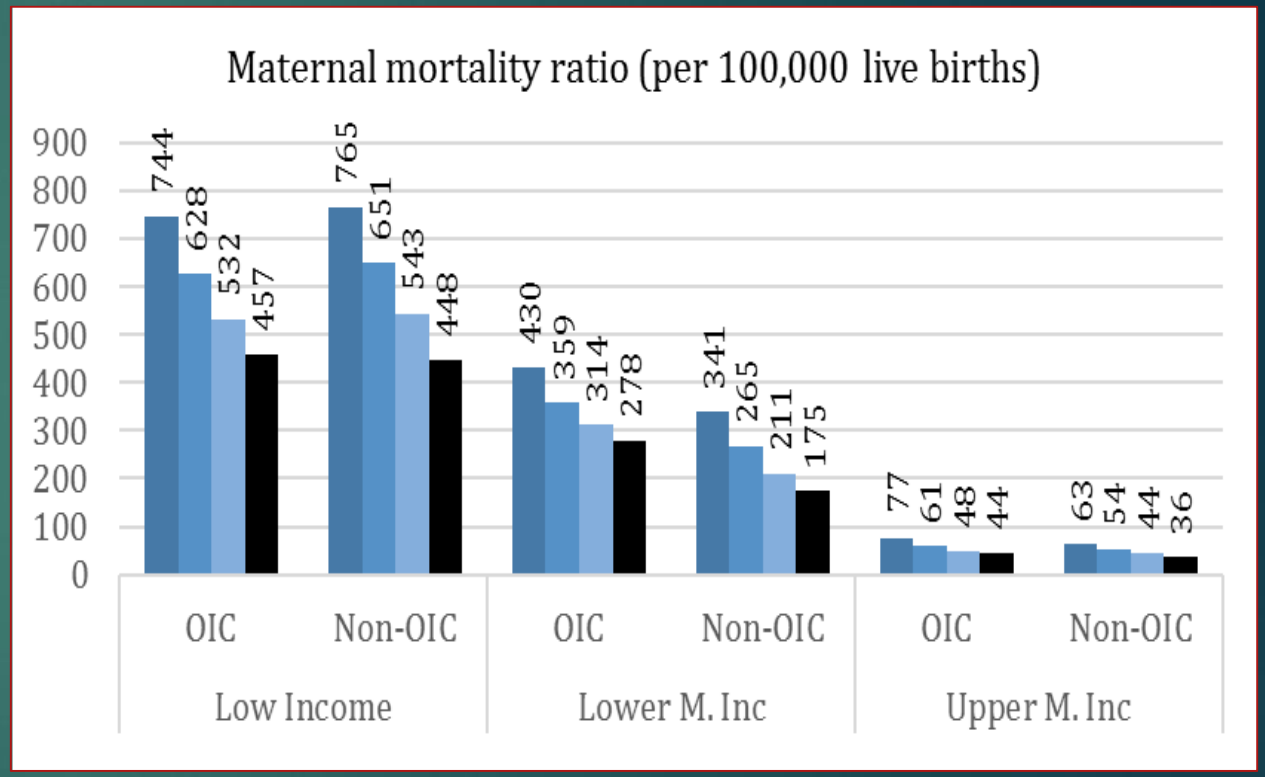
- All income-OIC subgroups have, over the years, improved life expectancy
- Richer groups lives longer compared to those in poorer countries
- OIC group fares less well than countries of the non-OIC group



Similar trend is seen with regard to maternal mortality ratio (MMR) and under five mortality rate (U5MR)

Access to Health; Health Status in OIC and Non OIC countries (cont'd)

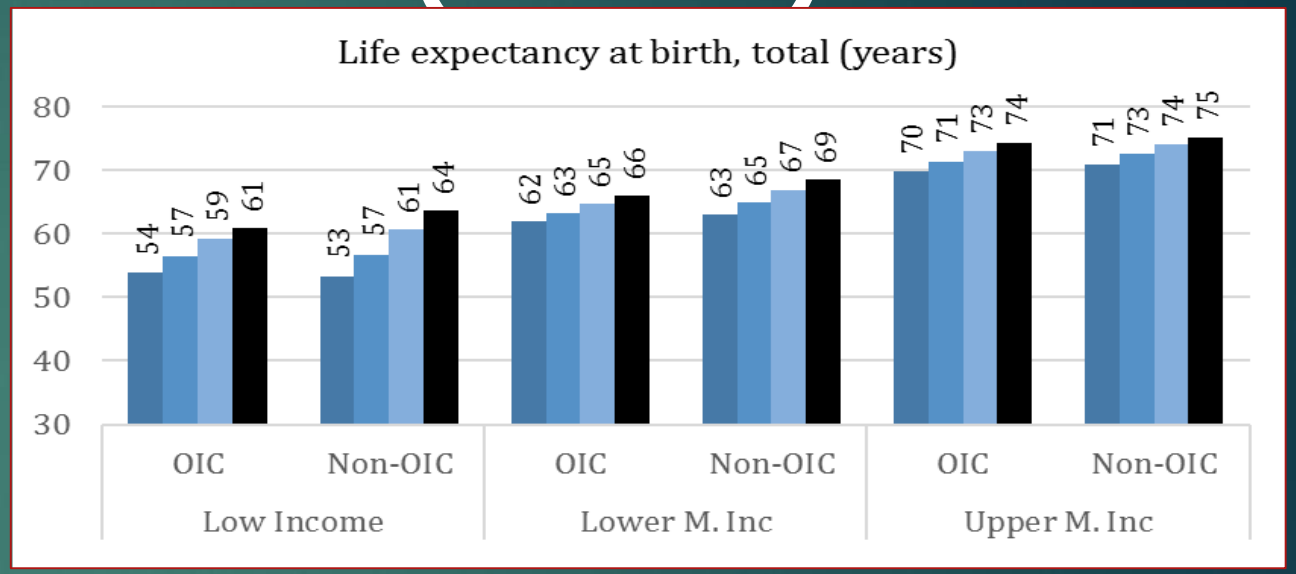


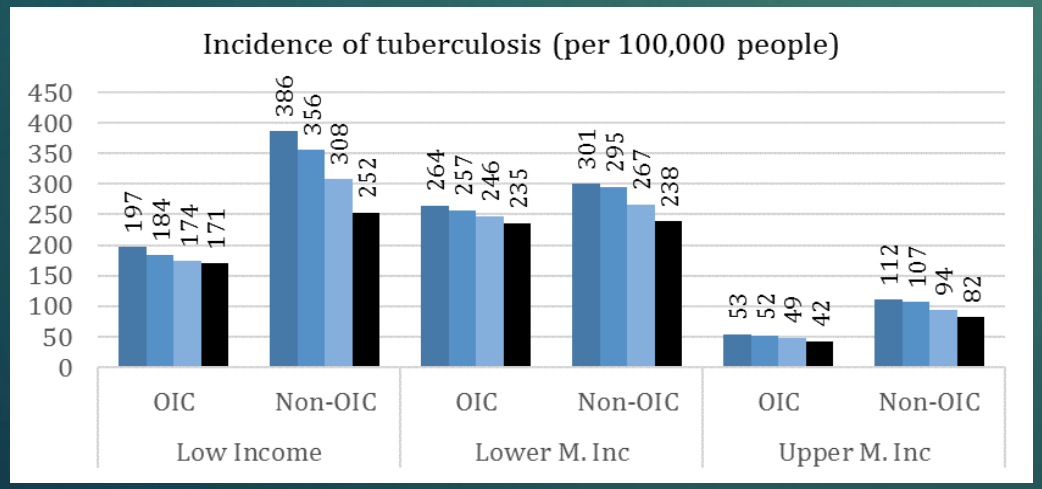


Access to Health; Health Status in OIC and Non OIC countries (cont'd)

Mortality from cardiovascular disease (CVD), cancer, diabetes or chronic respiratory disease (CRD)

- Moderate, yet consistent, improvement over the 20-year period for all income-OIC groups





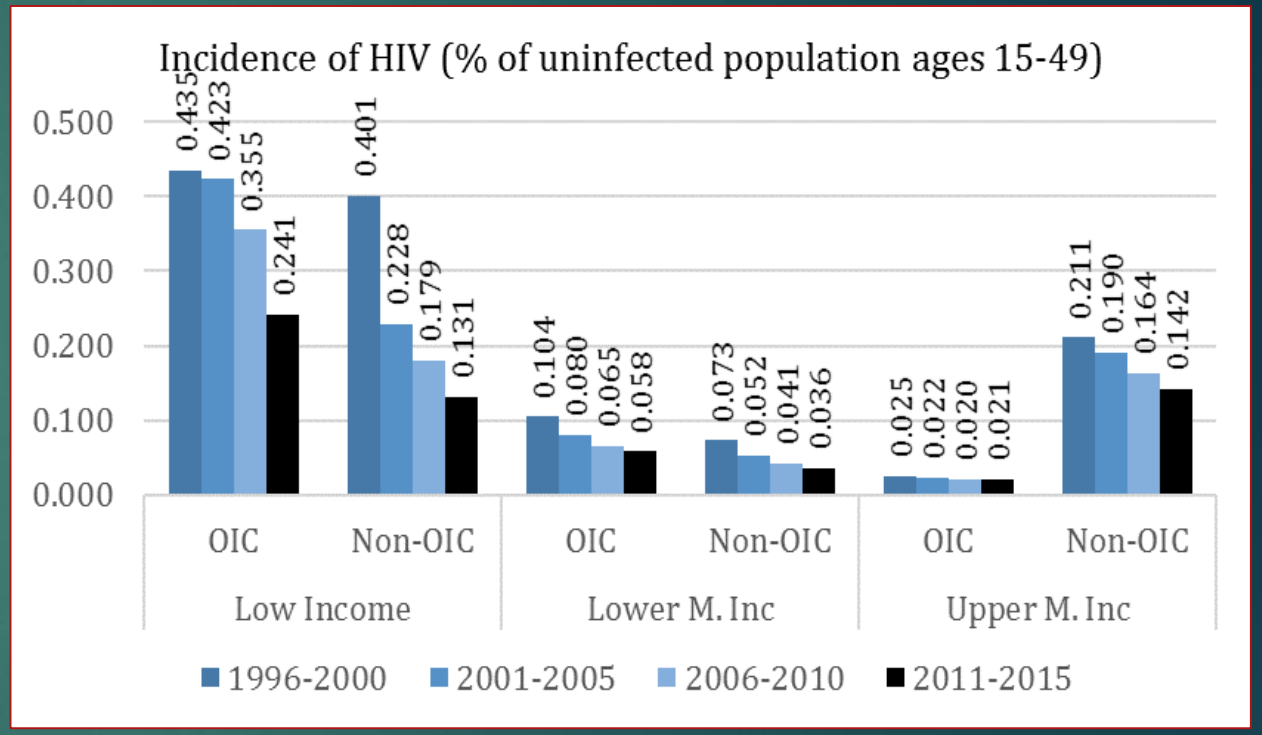
Number of new and relapse tuberculosis (TB) cases arising in a given year

- Incidence of TB had indeed fallen over the years
- Within group differences between OIC and non-OIC
- Lack of income effect?!

Access to Health; Health Status in OIC and Non OIC countries (cont'd)

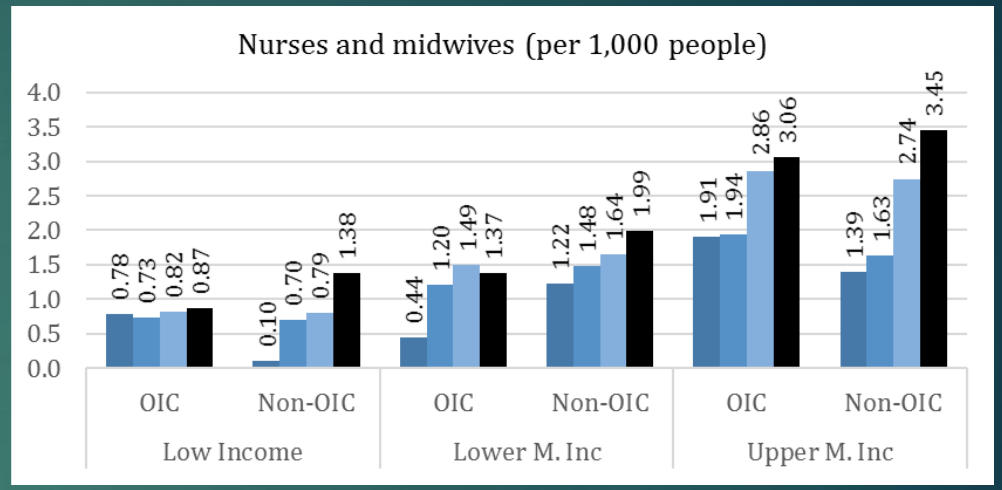
% of new HIV infections among uninfected population (15-49 yr.)

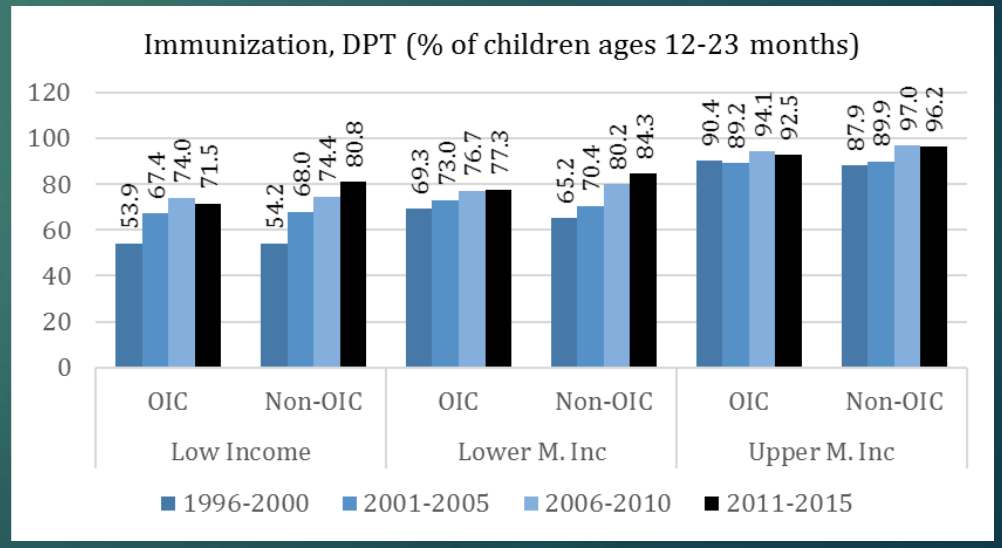
- non-OIC countries: incidence of HIV is lowest in middle income group. In OIC countries, the incidence of HIV steadily decreases with income level
- OIC countries tend to do less well than non-OIC countries in low and lower middle-income countries and its opposite for the high income group



Trends of access to health in OIC vs. non-OIC countries

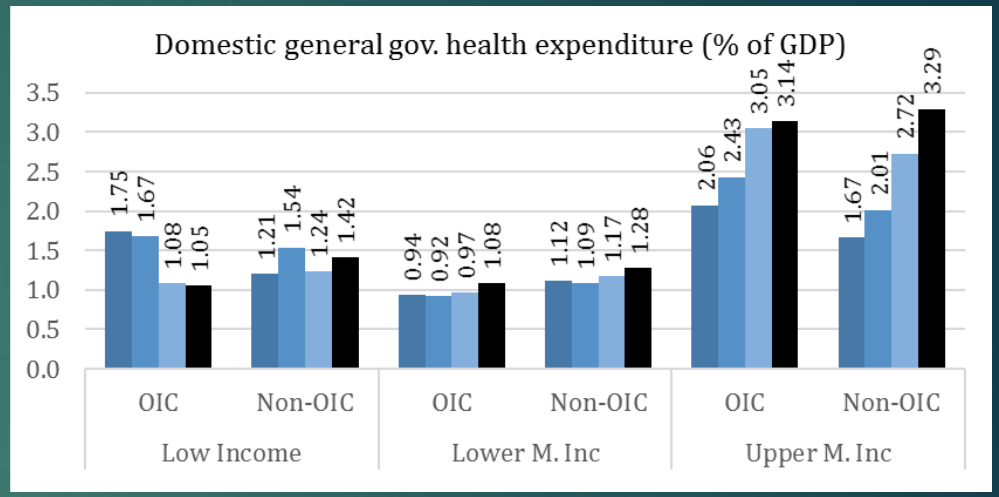
- Physical accessibility:
  - Indicators have not consistently increased throughout a 20-year period (even decreased DTP coverage in some cases) – especially worrisome since demand for health has increased
  - Corresponding improvement in respected groups by OIC and non-OIC shows that OIC has lower coverage

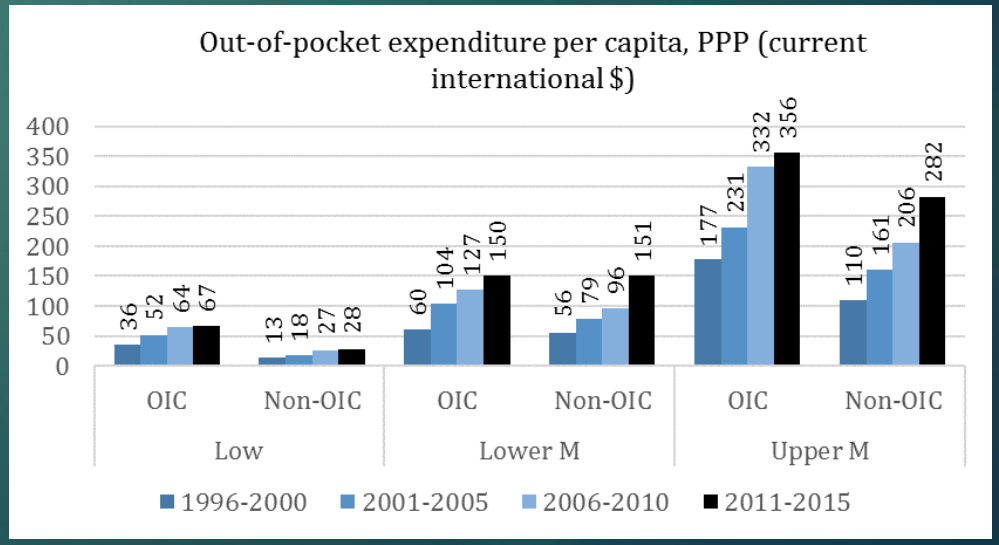




Trends of access to health in OIC vs. non-OIC countries

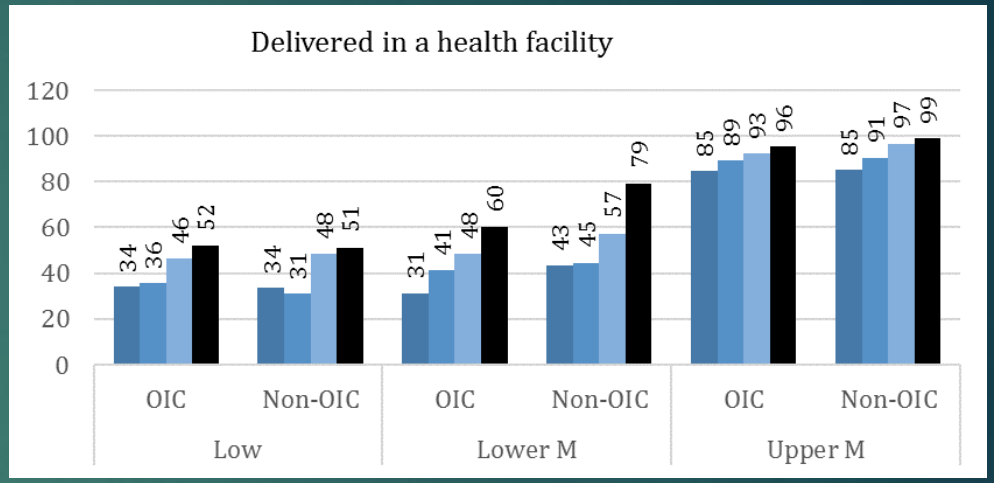
- Financial accessibility:
  - Financial investment in health has either stagnated or, in low-income OIC group, declined –only upper-middle-income countries managed to increase investment
  - Out of pocket expenditure on health is higher in OIC countries compared to non OIC countries, in general. And it shows a steady pattern of rise over the time

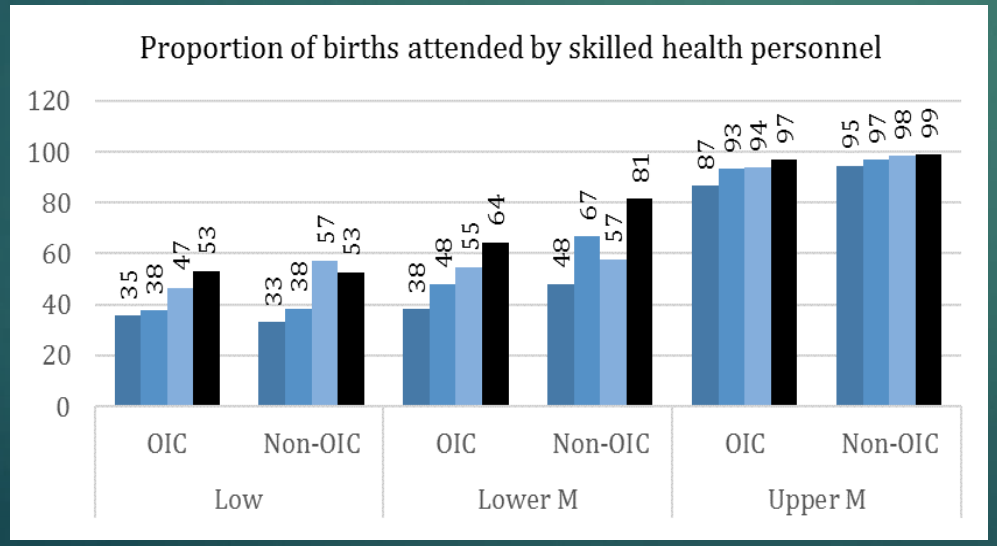


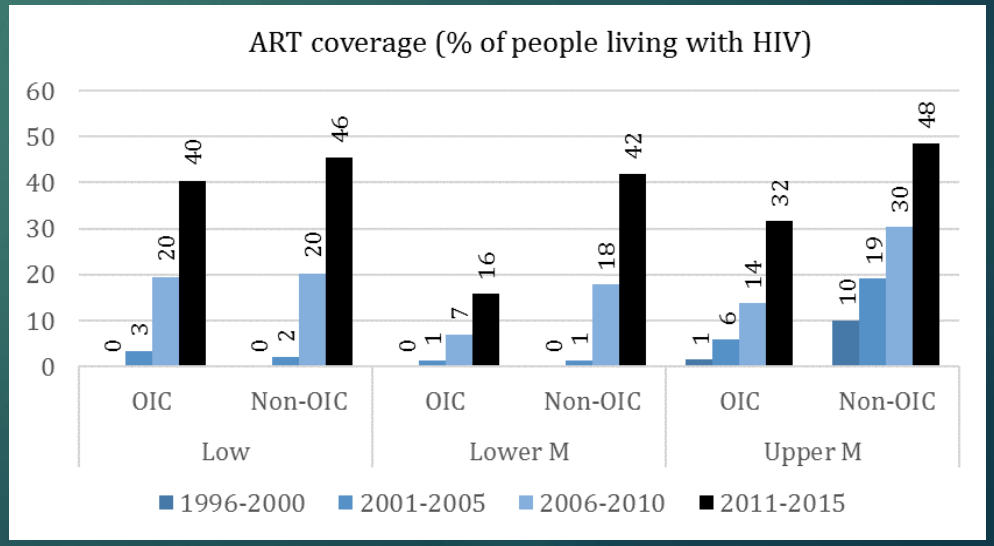


Trends of access to health in OIC vs. non-OIC countries

- Service accessibility:
  - Significant and consistent progress but still lagging behind non-OIC countries







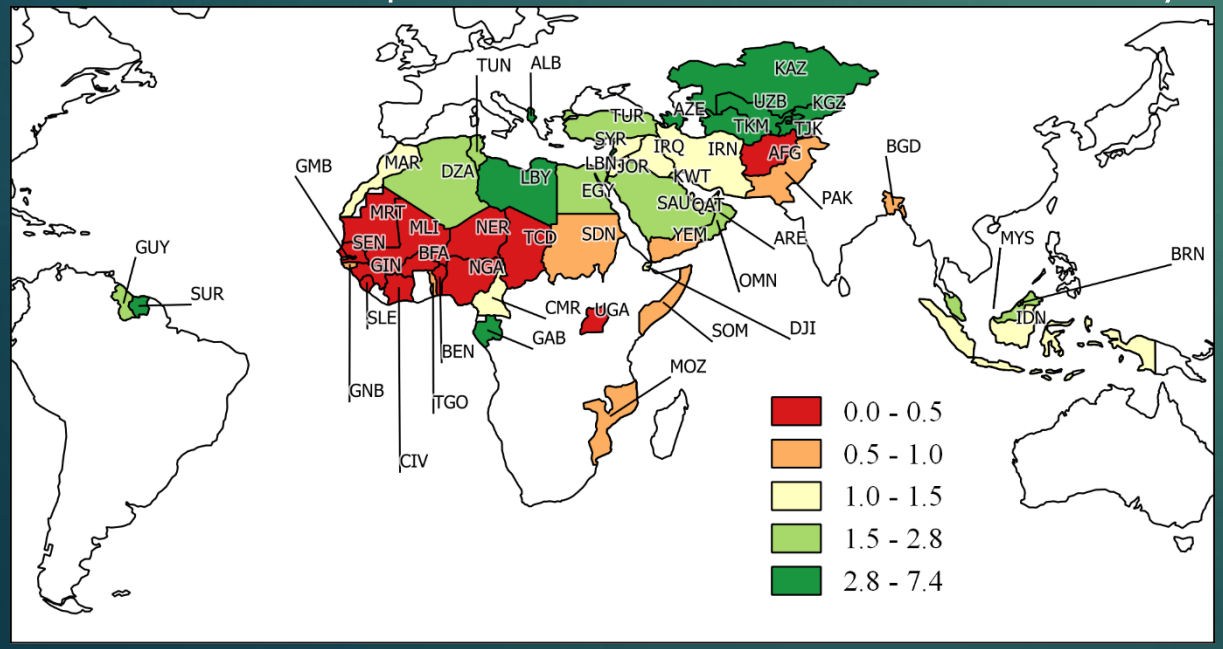
Demand for health services in OIC member countries

- Indicators of demand for health services: life expectancy at birth, under-5 mortality rate and maternal mortality rate
- High observed variation in outcomes and intra-OIC differences with Sub-Saharan Africa being worse off
- Overall increased life expectancy with women displaying higher levels than men
- Maternal mortality rates have fallen and high-skilled birth attendance is the key to preventing maternal and infant deaths

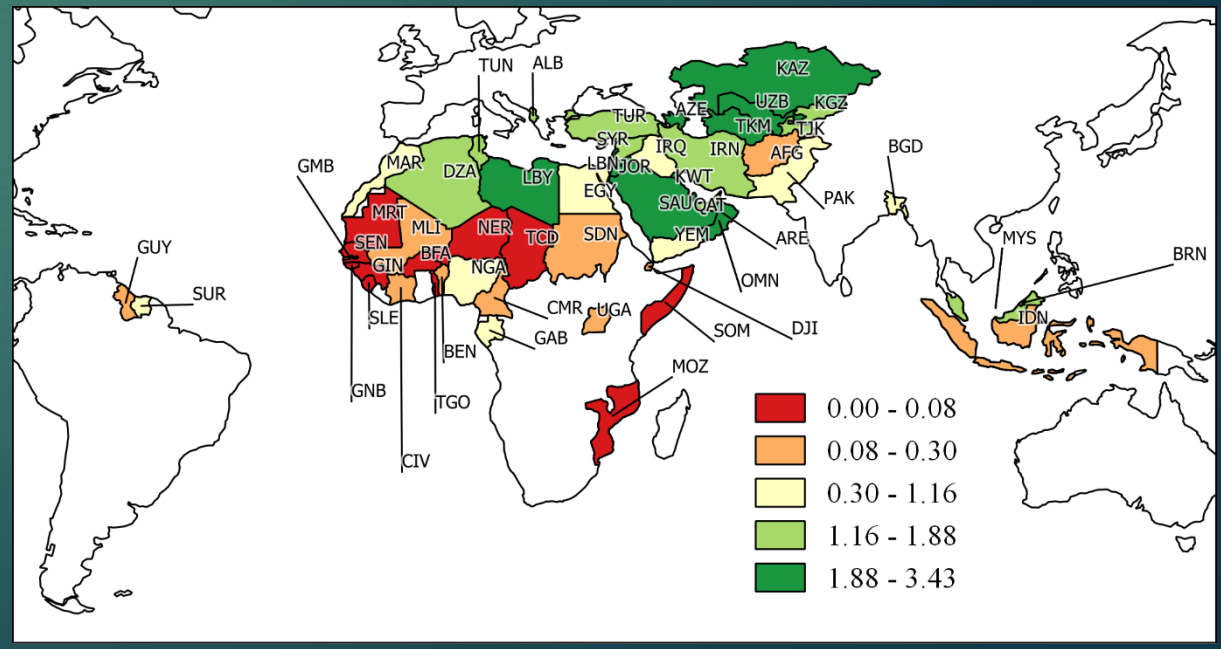
Access to healthcare services in OIC countries

- Physical access to healthcare
  - High intra-OIC variation
  - Average health staff ratio has increased, Arab and African OIC groups was better in the past, Asian group has improved
  - Hospital beds ratio has consistently declined in OIC countries

Hospital beds per 1,000 people



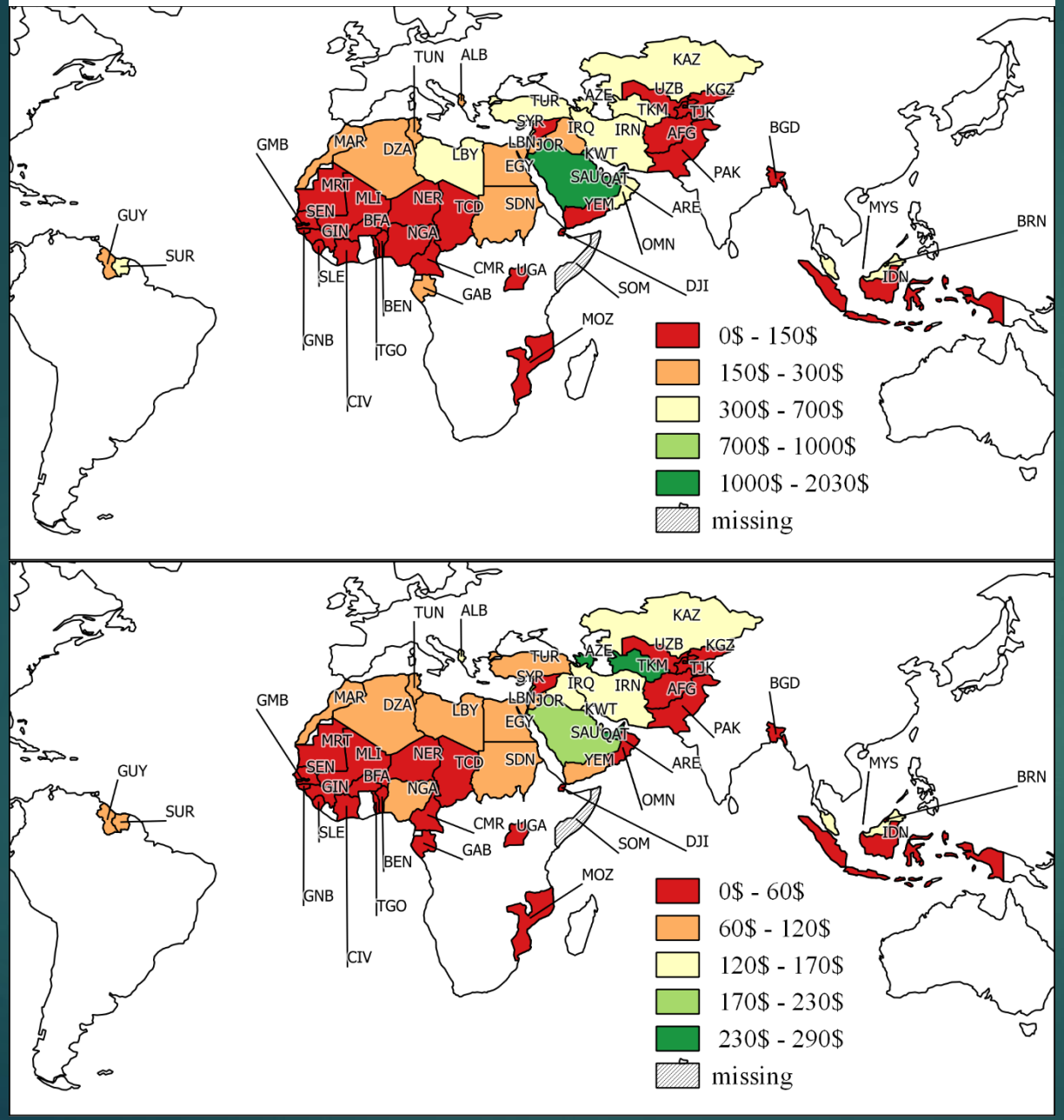
Physicians (per 1,000 people)



Access to healthcare services in OIC countries

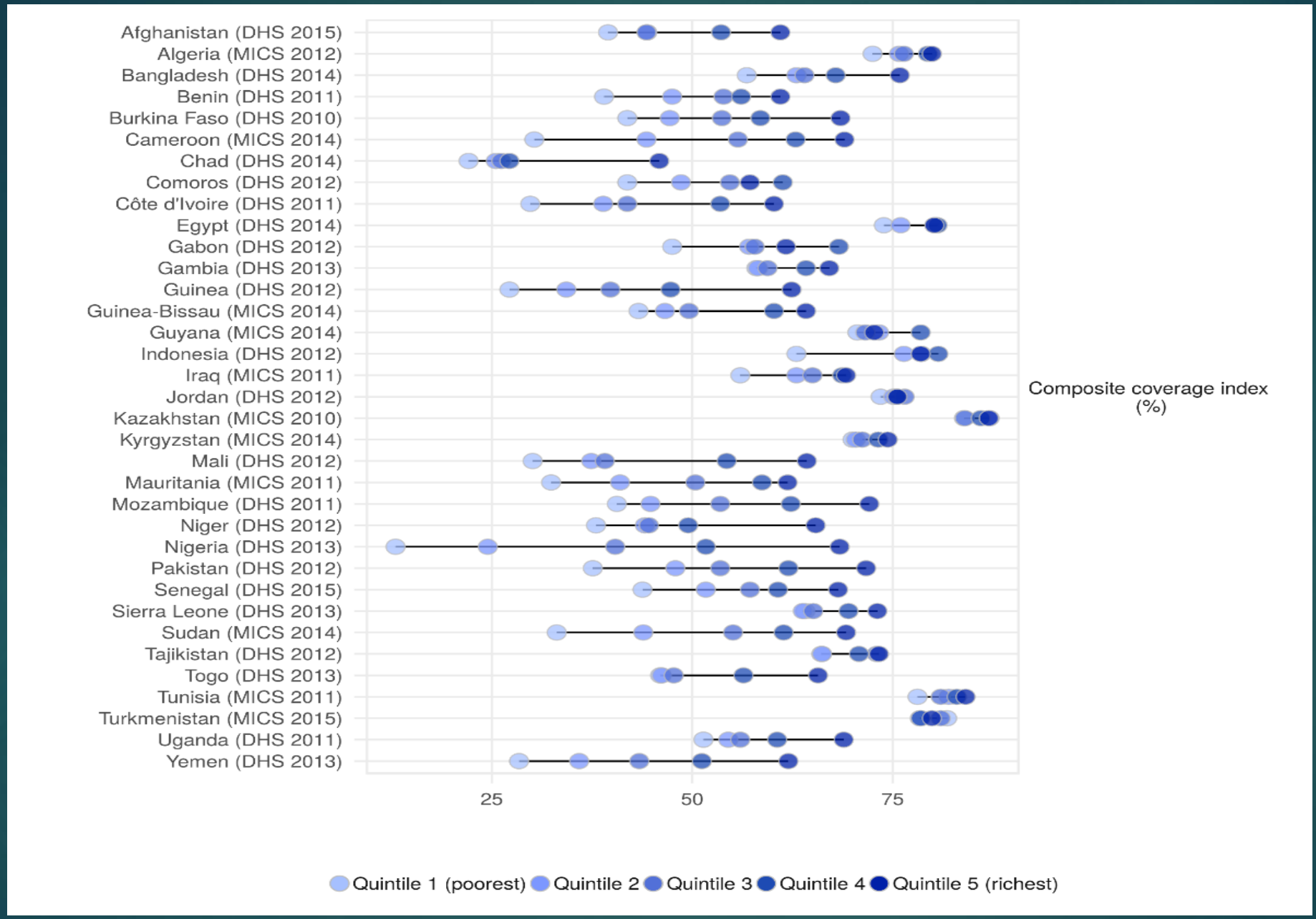
- Financial accessibility
  - Healthcare expenditure per capita has increased over time; Qatar, UAE and Saudi Arabia are the top 3 spenders with Guinea being in the bottom
  - Out-of-pocket expenditures have significantly increased; OOP is lowest in Sub-Saharan Africa and South Asia (in general)
  - Countries with low OOP also show low expenditure which might mean poor health infrastructure and services, restricted access etc.
  - Risk of catastrophic expenditure for surgical care is very high particularly in African countries

Current health expenditure per capita, PPP (current USD) in top panel and Out-of-pocket expenditure per capita (current USD) in bottom panel.



Wealth-disaggregated access to health and health outcomes across OIC countries

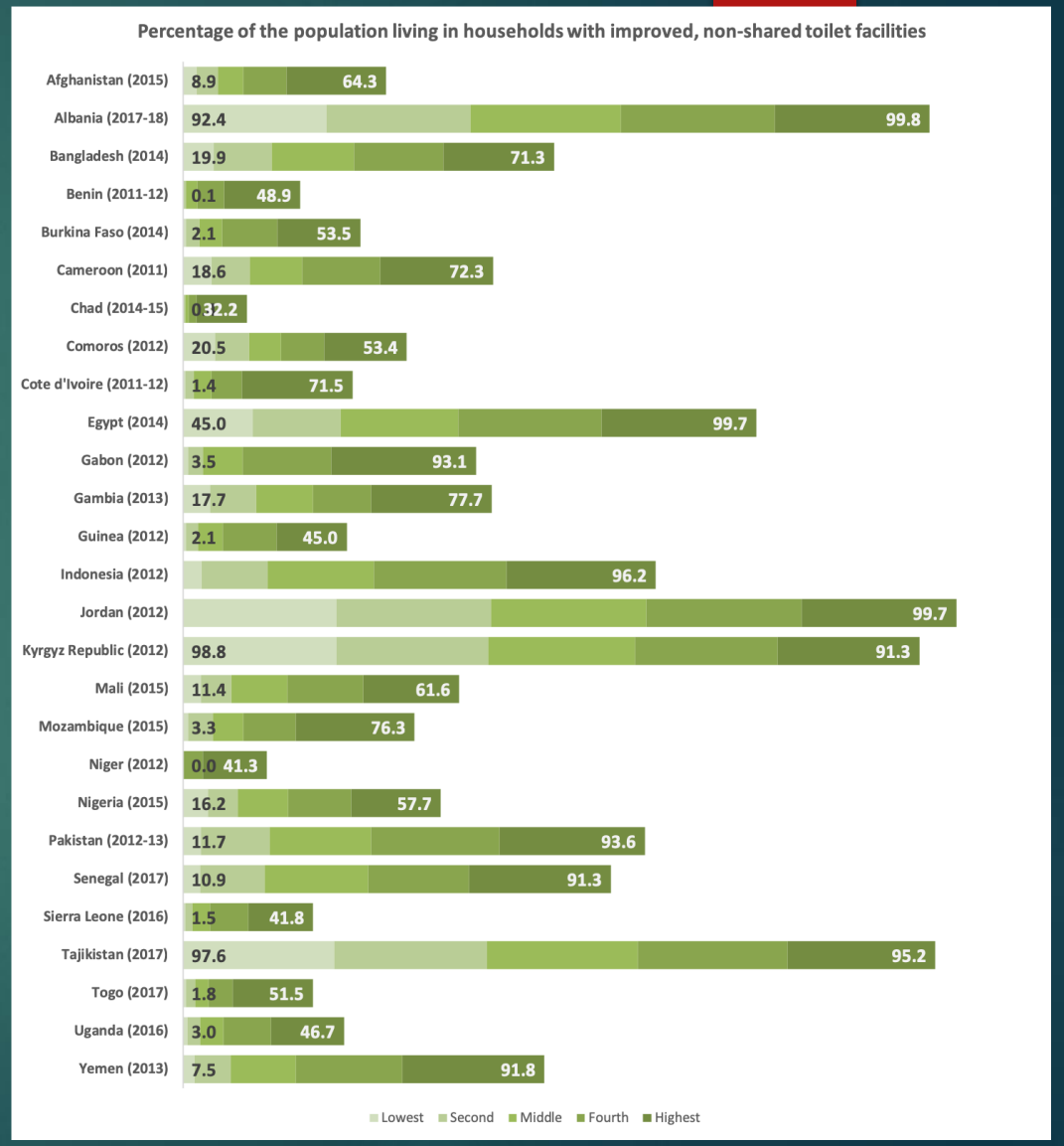
- Service coverage and its distribution across different wealth quintiles varies substantially across countries
- Access to health by the poor is particularly small in absolute terms and relation to richer populations in countries of the African region
- Algeria, Jordan, Kazakhstan, Kyrgyzstan and Turkmenistan are well-covered in terms of access to health care across all economic groups, including the poor
- In most countries we observe very large differences and a relatively 'steady' increase in access to health services with increasing wealth



Source: Health Equity Assessment Toolkit (HEAT): Software for exploring and comparing health inequalities in countries. Built-in database edition. Version 3.0. Geneva, World Health Organization, 2018

Wealth-disaggregated access to health and health outcomes across OIC countries

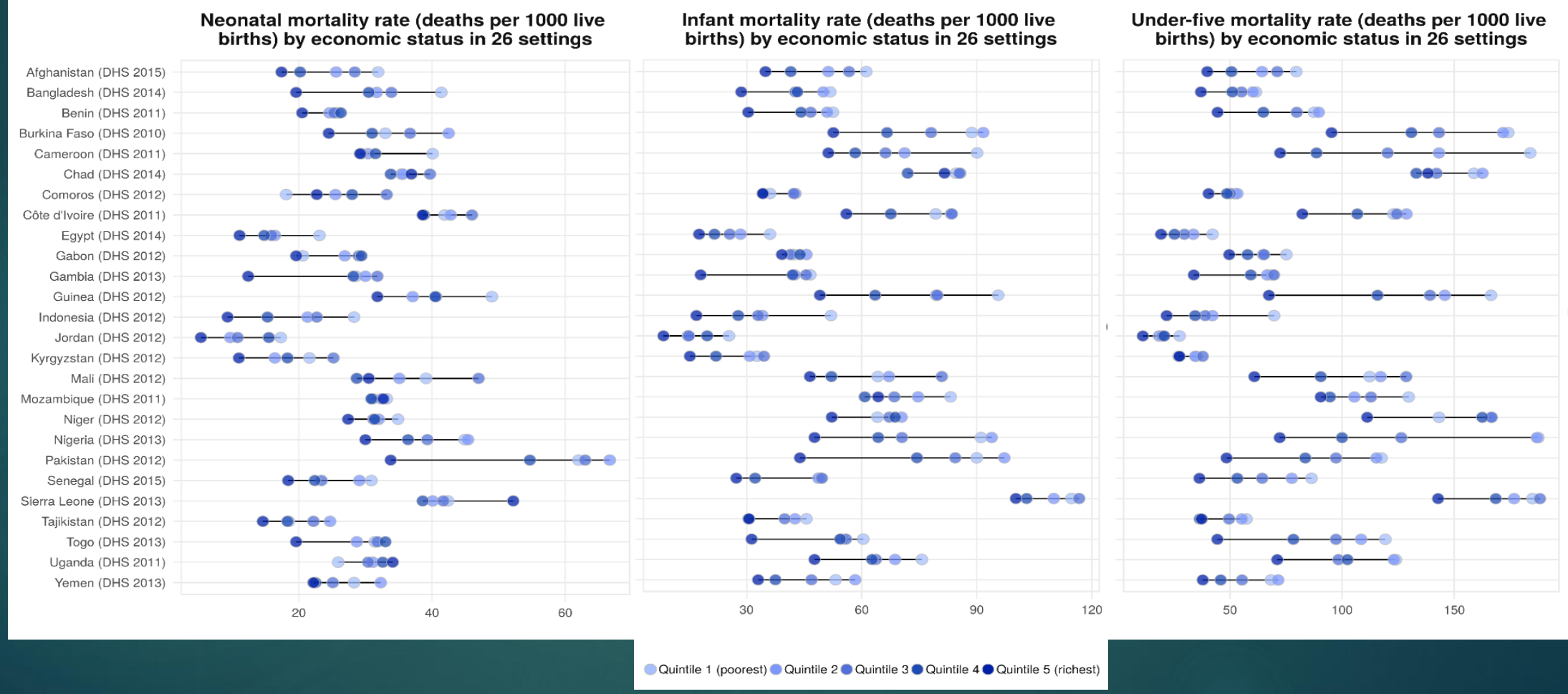
- Access to improved non-shared toilet facilities is also quite mixed
- In Jordan, Kyrgyz Republic, the Maldives, Tajikistan and Albania both poorest and richest have high levels of safe sanitation facilities
- In others, access to safe sanitation for the poorest is almost non-existent (Mauritania, Niger, Chad and Benin)



ICF, 2015. The DHS Program STATcompiler. Funded by USAID. http://www.statcompiler.com. January 31 2019

Wealth-disaggregated access to health and health outcomes across OIC countries

Neonatal, infant and under-5 mortality rates across OIC by wealth quintiles



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Regional policies related to access to health services within OIC region

- OIC Strategic Health Programme of Action (OIC-SHPA) for 2014-2023
  - Collaboration framework and action at national, OIC and international level
  - Six themes: Health system strengthening , Disease prevention and control, MNCH and nutrition, Medicines, vaccines & medical technologies, Emergency health response and intervention, Information, research, education and advocacy
- Middle-Eastern and North-African region (MENA) initiative
  - The World Bank's program for MENA (2013-2018): Promotion of equitable distribution of healthcare, financial protection and equitable responsiveness in terms of emerging diseases and health-related emergencies

The role of HMIS in Improving Access to Health Services in OIC countries

- Mostly outdated HMIS and unable to report actual status of healthcare
  - Outdated data collection systems, lack of trained personnel and appropriate technological equipment, lack of legislative and regulatory framework that facilitates the efficient use of health information systems
- Unreliable vital registration system
- Current OIC-SHPA addresses many of these problems

Questions?