Access to Health Care

equality of opportunity to a system of health care

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ATHYNA.EDUCATION

learning outcomes

By the end of the lecture and tutorial, students should be able to:

- Explain the concepts of access and equity in health care.
- Explain the concept of universal health coverage and its role in achieving equitable health outcomes.
- Differentiate between accessibility and availability of health care.
- Identify the groups of people most at risk of poor access and how these factors affect health equity.
- Describe the workforce issues contributing to poor access to healthcare in Australia.
- Apply the Tanahashi framework to identify barriers to access and utilization in healthcare.

This E-Book should be reviewed alongside the lecture videos and the *required reading* materials. This PDF is interactive. Please click on the links to navigate through the E-Book content.

table of contents

01
Introduction

02
about access to healthcare

08
universal health coverage

10
tanahashi framework of health services coverage

13
equity in access to healthcare

14
the impact of war and conflict on access to care

15
workforce issues contributing to poor access to healthcare in Australia

17
must know

01

INTRODUCTION

Access to comprehensive, quality healthcare services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity.

Cross-national epidemiological and econometric analyses show that health systems or elements within them promote population health, independent of other influences.

In this unit, access is understood not only in terms of the presence of health services, but also in relation to whether different groups in society can make use of those services in ways that are fair and compatible with the right to the highest attainable standard of health.

This eBook accompanies the lecture and tutorial on access to health care and equity in access.

It introduces key concepts, analytic frameworks, and empirical evidence that will help you examine how health system arrangements, social structures, and political decisions affect people's opportunities to receive appropriate care.

The focus is on the equality of opportunity to participate in a system of health care, and on the implications of unequal access for health equity.

ABOUT ACCESS TO HEALTHCARE

Are availability and accessibility to healthcare the same?

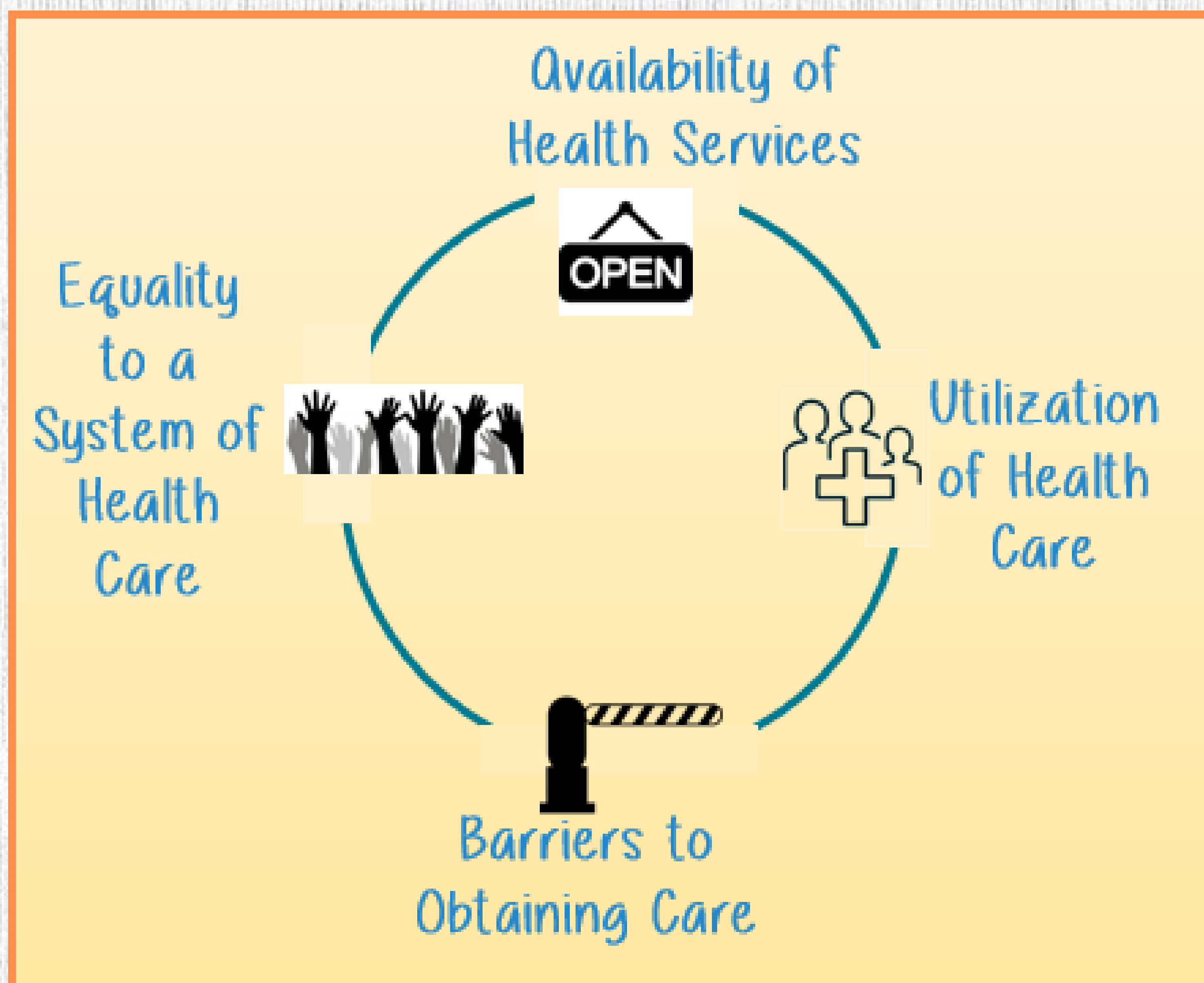
In earlier work on health systems, access was often treated as if it were synonymous with availability, understood as the presence of health personnel, facilities, and services at the time and place they were needed, with a clearly defined and known point of entry and fees considered appropriate to need (Freeborn & Greenlick, 1973). In this supply-oriented perspective, once sufficient services existed in a given area, access was assumed to have been achieved (Freeborn & Greenlick, 1973).

Subsequent analyses showed that the existence of facilities does not, by itself, ensure that people obtain care (Donabedian, 1972; World Health Organization, 2000).

Availability is therefore best understood as the existence and formal provision of health services, personnel, and facilities that can in principle be reached through an identifiable point of entry (Freeborn & Greenlick, 1973).

Accessibility, by contrast, refers more broadly to whether these services can be used by those who need them, rather than simply to whether they exist (Donabedian, 1972). A service may thus be available without being truly accessible, which helps to explain why significant access problems can persist in health systems that have considerable service capacity (World Health Organization, 2000).

Fig-1: Evolving Concept of Access to Health Care in the Literature



Evolving concept of accessibility or access in health care

The distinction between availability and accessibility introduced in the previous section reflects a wider shift in how access has been conceptualised in health services research. As we saw, earlier work focused primarily on availability (Freeborn & Greenlick, 1973). Within that supply-oriented view, access was generally regarded as secured once an apparently adequate set of services had been established (Freeborn & Greenlick, 1973).

Later analyses broadened this view by emphasizing that the presence of services does not, on its own, demonstrate access. They treated access as reflected in whether people who need care actually use services and are able to obtain appropriate and continuous care over time, rather than in the mere existence of facilities (Donabedian, 1972). This utilization-oriented perspective highlighted that accessibility concerns people's real ability to obtain care, not only the formal supply described under availability (Donabedian, 1972; World Health Organization, 2000).

Subsequent work added a further layer by examining the barriers that lie between availability and utilisation. It identified financial, organisational, informational, spatial and social obstacles that can prevent people from seeking or obtaining care even when services are formally available, thereby explaining how services may be available but not accessible in practice (Khan & Bhardwaj, 1994). These analyses showed that such barriers arise both on the side of service provision and on the side of potential users, linking the production and use of services within a single framework (Khan & Bhardwaj, 1994).

Together, these developments move from a narrow focus on availability to a multidimensional concept of accessibility that encompasses the presence of services, the extent to which they are used, and the barriers that mediate between supply and effective use (Donabedian, 1972; Freeborn & Greenlick, 1973; Khan & Bhardwaj, 1994; World Health Organization, 2000).

Barriers to Access

Having outlined how availability, utilisation and barriers together shape contemporary understandings of accessibility, it is useful to examine these barriers in more detail. Barriers arise both from the way health services are organised and distributed and from the circumstances in which people live, helping to explain how services can be available in principle but not accessible in practice (Khan & Bhardwaj, 1994).

On the service side, barriers are linked to the organisation and distribution of care. They include the number and mix of providers, the range of services offered, institutional arrangements, and the location of facilities (Khan & Bhardwaj, 1994). Socio-organisational features such as long waiting times, restricted opening hours, difficulties in securing appointments and fragmented referral pathways can impede entry into and movement through the health-care system, shaping whether individuals are able to obtain timely care (Donabedian, 1972). These aspects of service organisation shape whether people who wish to seek care can, in practice, gain timely contact with providers (Donabedian, 1972; World Health Organization, 2000).

On the side of potential users, barriers reflect informational, spatial, economic and social conditions. Limited knowledge of available services, entitlements and procedures can delay or prevent help-seeking (Khan & Bhardwaj, 1994). Distance to facilities and inadequate transport options create difficulties in reaching care, particularly for people living in rural or remote areas (Khan & Bhardwaj, 1994). Economic barriers, including user fees and other out-of-

pocket payments, may discourage or prevent individuals from seeking care, even when services are formally available (World Health Organization, 2000). These constraints interact with broader social circumstances so that the same level of cost, distance or time may be manageable for some but prohibitive for others (Khan & Bhardwaj, 1994).

Health literacy significantly affects a person's ability to navigate the healthcare system. Individuals with limited health literacy may not recognise the need for care, understand how to seek services, or comply with treatment, contributing to disparities in access (Syed et al., 2013).

Cultural, linguistic and social factors further shape access. Language barriers can limit communication with providers and understanding of health information, particularly among immigrant populations (Flores, 2006; Diamond et al., 2009). Social exclusion and discrimination based on race, ethnicity, gender, or legal status may lead to distrust and reduced utilisation of services among marginalized groups (Hall et al., 2015).

Further, stigma, particularly around mental health, can deter individuals from seeking care. This is further complicated for minority groups, where cultural perceptions of health and mental illness can affect willingness to access healthcare services (Corrigan, 2004).

There is also increasing recognition of the role of broader social factors, including social support, community resources, and experiences within health facilities, in shaping access to care, especially among minority groups and under-served populations (Gresenz et al., 2007).

Understanding barriers in this way makes visible the processes through which particular groups experience poorer access to care and provides an analytic basis for examining instances of delayed or foregone care, such as those seen in maternal health (Khan & Bhardwaj, 1994; World Health Organization, 2000).

Barriers to Accessing Care: Case Example of Maternal Health

In 2020, the World Health Organization (WHO) reported that over 800 women succumbed to preventable causes associated with pregnancy and childbirth (WHO, 2023). The inherent injustice lies in the preventability of these fatalities. Furthermore, there is widespread consensus that interventions aimed at reducing maternal, fetal, and neonatal mortality, such as the provision of skilled birth attendants and referral services for essential obstetric and neonatal care during complicated deliveries, are economically feasible. However, their effectiveness is contingent upon the functionality of a

robust health system.

Thaddeus and Maine (1994), upon reviewing empirical evidence, explicated the heightened maternal morbidity and mortality rates in low-income countries through the lens of the Three Delays Model. This model elucidates how maternal mortality is intricately linked to impediments hindering access to timely obstetric care.

The first delay occurs in the decision to seek care, influenced by individual recognition of complications, social and cultural factors, and financial considerations.

The second delay arises during the transport to a healthcare facility, which may involve logistical, geographic, and infrastructural challenges.

The third delay happens upon arrival at the healthcare facility, where potential shortages of staff, supplies, or a lack of appropriate medical response can further hinder timely and effective care.

This model emphasizes that improvements in maternal health require multifaceted interventions addressing each of these delays.

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Did you know?

- **Maternal death**: Death of a woman during pregnancy or within 42 days of termination, from causes related to or aggravated by the pregnancy or its management, excluding accidental causes.
- ~92% occur in low- and lower-middle-income countries
- Sub-Saharan Africa (~70%) and South Asia (~17%) account for the majority
- Around 75% are due to: severe bleeding (haemorrhage), infections, hypertensive disorders (e.g., pre-eclampsia), complications from delivery, unsafe abortion

(WHO, 2023)

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UNIVERSAL HEALTH COVERAGE

Health For People, Not For Profits

Universal health coverage (UHC) refers to ensuring that all people have access to needed health services without financial hardship (World Health Organization [WHO], 2023). It encompasses a continuum of care, including health promotion, prevention, treatment, rehabilitation, and palliative services delivered at sufficient quality to be effective (WHO, 2023). UHC is identified as a target within the Sustainable Development Goals and is associated with efforts to improve equity in access to health services (WHO, 2023; Marmot et al., 2008).

In the literature, UHC is commonly understood in terms of three interrelated dimensions: service coverage, financial protection, and population coverage (Abiiro & De Allegri, 2015). These dimensions provide a framework for assessing how health systems deliver services, protect individuals from financial risk, and include different population groups (Abiiro & De Allegri, 2015). Population coverage refers to the extent to which different groups are included within health systems and are able to access services (Abiiro & De Allegri, 2015).

Financial protection is a central component of UHC, with an emphasis on reducing direct out-of-pocket payments at the point of service use (WHO, 2023). This is achieved through greater reliance on pooled, prepaid financing mechanisms such as taxation or insurance (WHO, 2023; Abiiro & De Allegri, 2015).

Progress toward UHC has been uneven. Global monitoring data

indicate that service coverage has improved but has slowed since 2015, while a substantial proportion of the population continues to experience financial hardship due to out-of-pocket health spending (WHO, 2023). Within countries, inequalities in service coverage persist across population groups, including differences by socioeconomic status and place of residence (WHO, 2023). The COVID-19 pandemic disrupted essential health services in many settings, highlighting vulnerabilities in health systems and the importance of maintaining service delivery during crises (WHO, 2023).

In summary, UHC encompasses interrelated objectives relating to service coverage, financial protection, and population coverage, with the aim of ensuring access to needed health services without financial hardship (WHO, 2023; Abiiro & De Allegri, 2015).

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TANAHASHI FRAMEWORK OF HEALTH SERVICES COVERAGE

In health systems research, coverage refers to the proportion of a population in need of a health service that actually receives that service, and is commonly used as an indicator of health system performance (World Health Organization [WHO], 2010; Boerma et al., 2014). This concept differs from access, which concerns the conditions that enable or prevent individuals from obtaining care, and from utilisation, which refers to the actual use of services (Donabedian, 1972; Khan & Bhardwaj, 1994; WHO, 2000). Coverage therefore provides a population-level measure of the extent to which health needs are met.

The Tanahashi model builds on this concept by examining how coverage is reduced at successive stages between the existence of services and the delivery of effective care (Tanahashi, 1978). It distinguishes between potential coverage, referring to the availability of services to a population, and effective coverage, referring to the proportion of the population that ultimately receives care of sufficient quality to produce a meaningful health outcome (Tanahashi, 1978; Boerma et al., 2014).

The model conceptualises coverage as a sequence of stages through which individuals must pass. At each stage, a proportion of the population is lost, resulting in progressively lower levels of coverage.

Availability coverage refers to the proportion of the population for

whom the service exists, determined by the presence of infrastructure, workforce, and resources.

Accessibility coverage refers to the proportion of the population that can reach and use these services, reflecting barriers such as cost, distance, and organisational constraints.

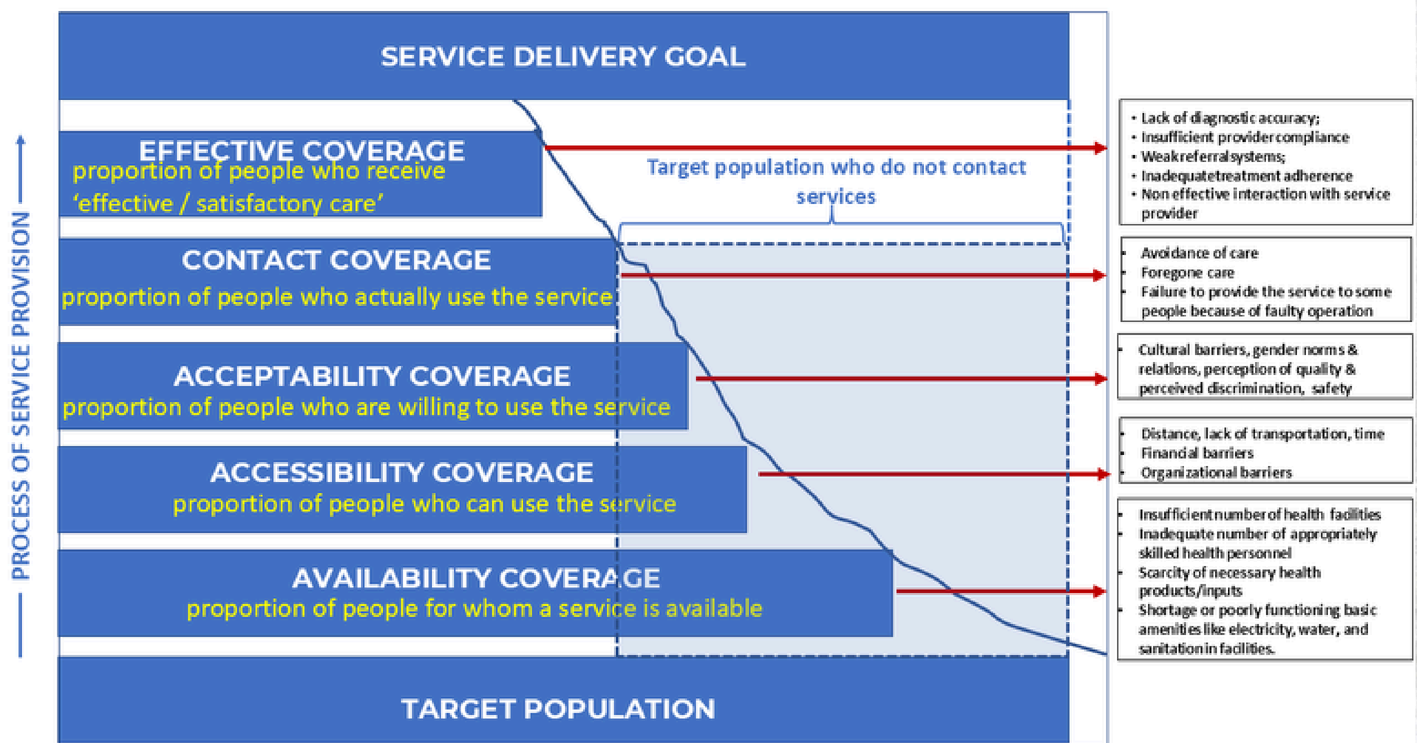
Acceptability coverage refers to the proportion of the population that is willing to use services, shaped by cultural norms, perceptions of quality, trust, and experiences of discrimination.

Contact coverage refers to the proportion of the population that actually utilizes services, corresponding to realized utilization.

Effective coverage refers to the proportion of the population that ultimately receives care that produces health benefit.

The key contribution of the Tanahashi model is that it demonstrates that access and utilization do not, on their

Fig-4: The Tanahashi Framework of Access



own, ensure that health needs are met. A service may be available and accessible, and may even be used, yet still fail to produce a health benefit if the quality of care is inadequate. Individuals may not utilise services despite their availability and accessibility due to social or cultural barriers, and even when services are utilised, the care provided may be insufficiently effective to improve health outcomes. By identifying losses at each stage between availability, access, utilisation, and effective care, the model provides a structured approach to analysing gaps in health system performance.

In summary, the Tanahashi framework complements earlier concepts of access by situating them within a broader analysis of coverage, allowing for systematic identification of where and why populations fail to receive effective care.

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$$\text{Effective Coverage} = \frac{\text{Population receiving care that produces health gain}}{\text{Population in need}}$$

EQUITY IN ACCESS TO HEALTH CARE

Equity, as we know, is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Similar treatment to all people all the time in different contexts (equality) does not always embody fairness (equity) because people's needs, resources, and contexts are different.

Equity in Access to Health Care Utilization

Horizontal Equity in healthcare utilization pertains to ensuring that individuals with similar health needs have similar access to healthcare services, irrespective of their socio-economic status.

Vertical Equity in healthcare utilization involves providing health care preferentially to those with the greatest need (WHO, 2000).

Equity in Access to Health Care Financing

Horizontal Equity in health care financing denotes equal financial contribution and ability to pay for healthcare services regardless of demographic factors such as gender, marital status, or residential location.

Vertical Equity in health care financing means that those with unequal ability to pay, make appropriately dissimilar payments for health care. It entails adjusting the financial burden of healthcare payments based on individuals' varying abilities to pay, ensuring fair distribution of costs among different socio-economic groups.

Current Egalitarian Practice

Horizontal Equity is upheld in healthcare utilization, ensuring that individuals with similar health needs receive equal access to healthcare services regardless of their socio-economic circumstances.

Vertical Equity is prioritized in healthcare financing, ensuring that individuals with varying abilities to pay contribute proportionately to their respective financial capacities, thereby promoting fair distribution of healthcare costs.

THE IMPACT OF WAR AND CONFLICT ON ACCESS TO CARE

The impact of contemporary complex and protracted conflicts and war on health is manifold. Health problems in such contexts include trauma injuries, mental health disorders, spread of infectious diseases, and loss of continuity of care for chronic conditions. Outbreaks related to acute jaundice syndrome, polio, acute bloody diarrhoea, and typhoid have been reported in the ongoing conflict in Syria. Deaths due to extreme cold and the lack of medical care for mothers before and during birth, and for new infants have also been reported.

The Lancet (2018) reports that health facilities in Afghanistan, Burkina Faso, the Central African Republic, Egypt, and Turkey have also been forced to close as a result of conflict. In addition, war and conflict impacts the determinants of health such as water and food. Health infrastructure such as hospital facilities are destroyed and accompanied by deaths and kidnappings of doctors and other medical staff.

Neighboring countries are not spared the impact of war. Owing to the confli in Syria, the World Health Organization (2015) reported that outbreaks of measles and polio in Jordan and TB, diarrhoea, measles, mumps, hepatitis A, and cholera in Lebanon remain a concern in spite of active surveillance and routine immunization (for vaccine-preventable diseases) in the community by the authorities. Jordan reported an increased demand for surgical and trauma care, cancer treatment, mental health and psychosocial care (Hunter, 2016), and treatment for non-communicable diseases (NCDs) (Doocy et al., 2016).

Delivering equitable universal health care becomes a challenge in such a situation.

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WORKFORCE ISSUES CONTRIBUTING TO POOR ACCESS TO HEALTHCARE IN AUSTRALIA

The healthcare workforce in Australia faces several challenges that contribute to poor access to healthcare, particularly in rural and remote areas. These issues predominantly relate to workforce shortages, maldistribution, and the complexities of delivering healthcare in diverse and often isolated settings.

Workforce Shortages

Australia faces significant healthcare workforce shortages not only in terms of the number of healthcare professionals but also qualitatively, reflecting a lack of specialists and general practitioners willing to work in underserved areas. This shortage directly impacts the accessibility and quality of healthcare services

available to rural populations (Russell et al., 2017).

Maldistribution of Healthcare Professionals

The distribution imbalance is evident in the disparity of healthcare professionals per population between major cities and rural areas. In 2014, there were significantly fewer full-time equivalent medical practitioners per 100,000 population in outer regional and remote areas compared to major cities, leading to poorer health outcomes, higher rates of chronic diseases, and lower life expectancy in rural and remote regions (Coopes, 2020; Phillips, 2015)

This unequal distribution extends to medical specialists, dental practitioners, and allied health professionals. Such an urban-centric distribution leaves rural areas particularly vulnerable, with fewer healthcare resources and professionals to address the health needs of these communities (Australian Institute of Health and Welfare, 2023). Further, factors such as professional isolation and limited career and educational opportunities exacerbate the high turnover rates among rural healthcare professionals (Humphreys et al., 2007).

Rural Healthcare Delivery Challenges

Delivering healthcare in rural and remote areas of Australia presents unique obstacles, including geographic isolation, limited infrastructure, and smaller patient populations. These factors combine to create difficulties in attracting and retaining healthcare professionals, further worsening access issues for rural communities (National Rural Health Alliance, 2018).

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MUST KNOW

- The concepts of access and equity in health care utilization and health care financing.
- The difference between accessibility and availability of health care
- The Tanahashi Framework of Access
- Workforce issues contributing to poor access to healthcare in Australia

Access to Health Care

equality of opportunity to a system of health care

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THEME II:POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1

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