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**HEALTH POLICY  
INITIATIVE**

# Policy Approaches to Achieving Equity in Health:

## An Overview

Presenter's Name

Date



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# What Is Equity in Health?

**Equity = Absence of Inequity**

Health inequity refers to differences among groups that are

- Unnecessary
- Avoidable
- Unfair
- Unjust

# Inequity in Infant Mortality

**Children born to poor mothers are more likely to die before reaching their first birthday than those born to wealthier mothers.**

- In developing countries, the main causes of infant mortality are linked to low birthweight, preventable diseases, diarrhea, and acute respiratory infection.
- Most of these causes can be avoided through adequate water supplies and sanitation, better nutrition, and use of primary healthcare.
- Better-off families have better access to the means of prevention than poor families.

**Therefore, poverty-related differences in infant mortality meet the criteria for inequity.**

# Inequity in Unintended Births

**Poor women have more children on average than better-off women.**

- Fertility rates are determined by age at marriage and use of effective family planning, among other factors.
- Girls from poor families tend to drop out of school and marry earlier than girls from better-off families.
- Poor women are less likely to use contraception than better-off women; they also are less likely to use effective methods.

**Therefore, poverty-related differences in unintended births meet the criteria for inequity.**

# How Is Inequity Usually Expressed in Analyses?

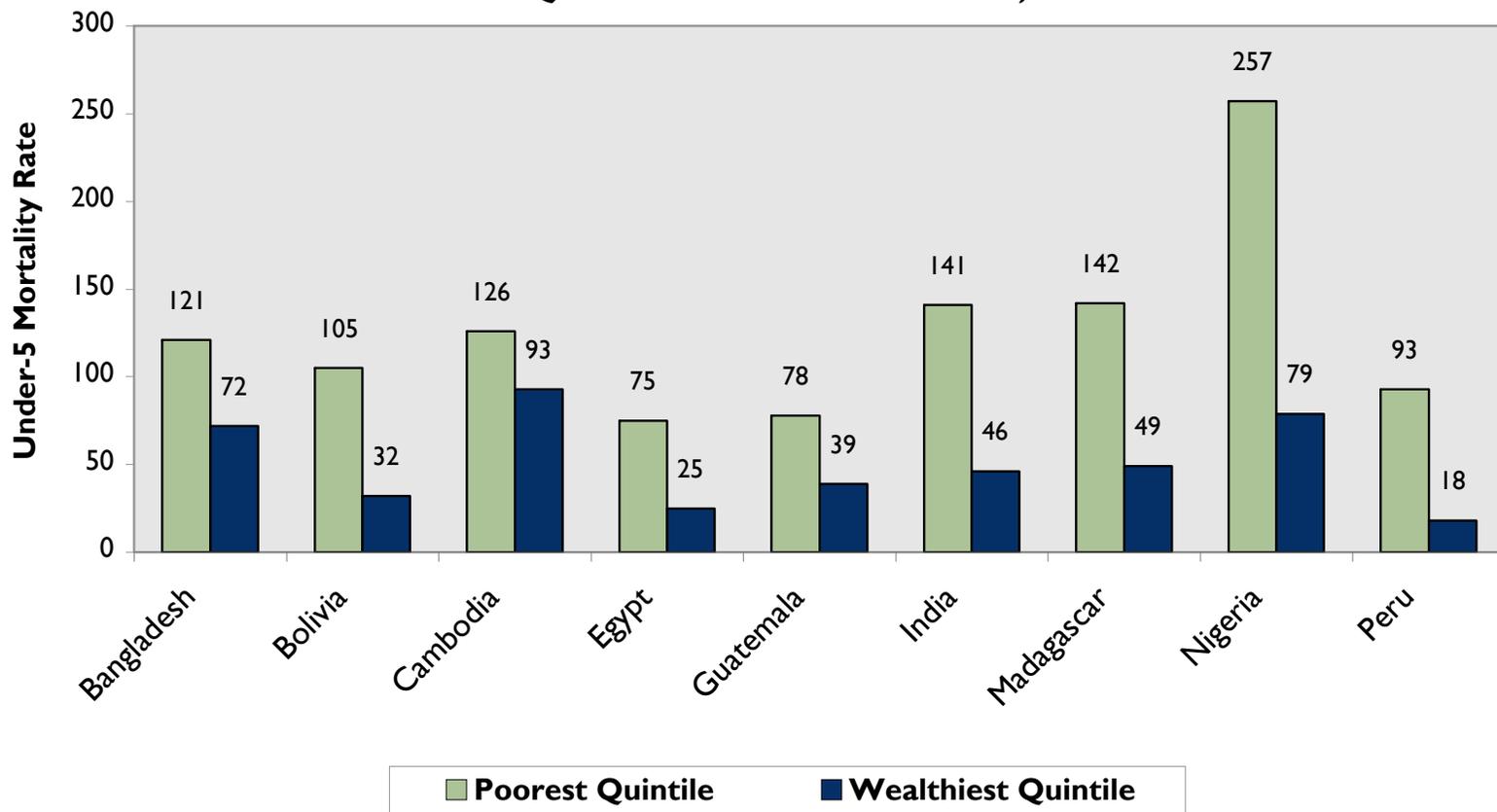
- Analyses demonstrate inequities by using likelihood, proportions, or rates.
- Absolute numbers may or may not signify inequity.
  - For example, we may find more deaths among poor children than deaths among children from better-off families.
  - However, if there are more poor children than better-off children in the general population, the difference in numbers of deaths do not necessarily indicate inequity.

# Expressing Inequity

- Inequities may be found in negative indicators (infant mortality rates), as well as positive indicators (completion of secondary education).
- Inequities may be found in
  - Health outcomes or health status (malnutrition);
  - Use of health services (childhood vaccination); and
  - Distribution of health services (percentage of population within 30 minutes of a health facility).
- Failure to use a health service does not necessarily mean that the service is unavailable. Other factors may be in play.

# The Poor Have Worse Health Outcomes Than the Better-Off

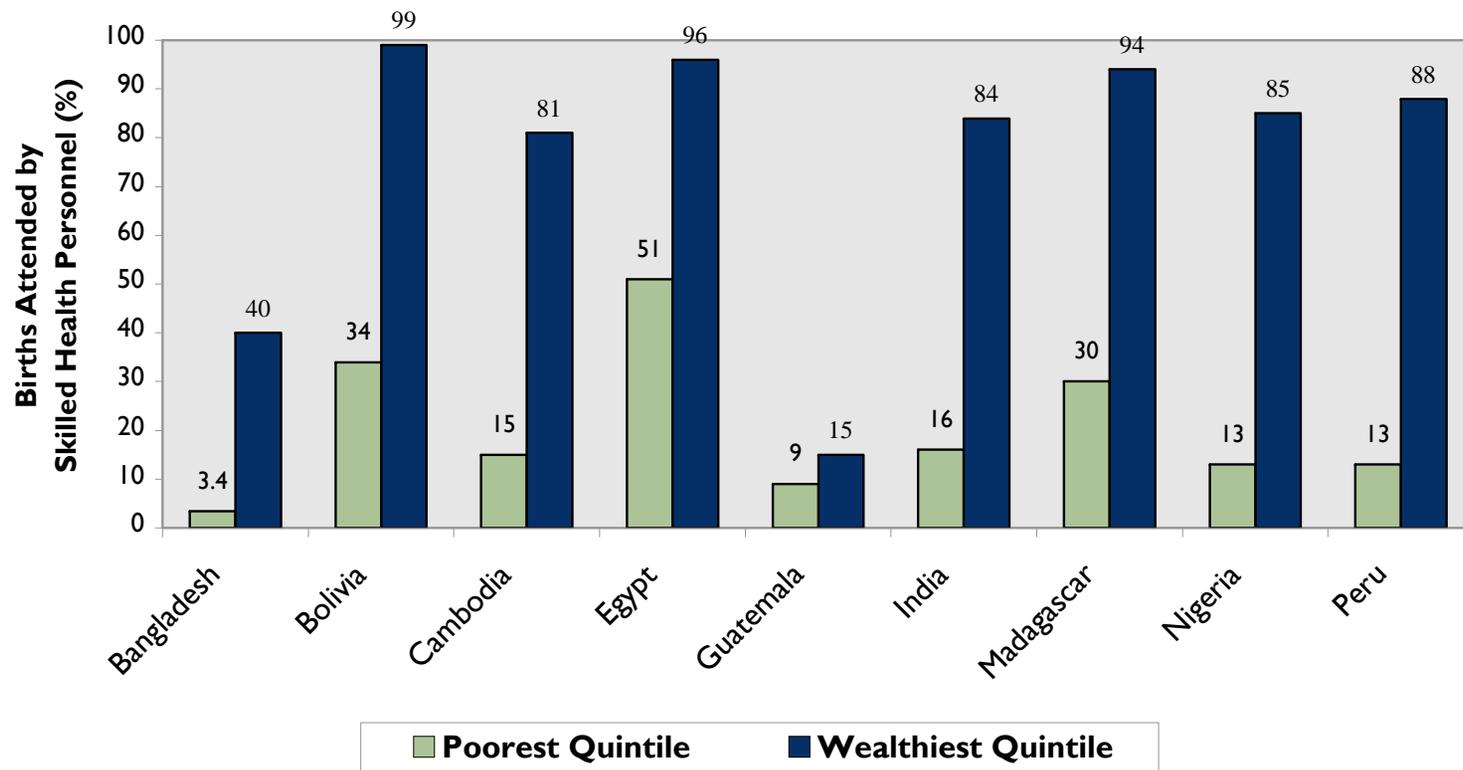
Under-5 Mortality Rate for Poorest and Wealthiest Quintiles in Nine Countries, 2007



Source: WHO. 2007. *World Health Statistics 2007*. Geneva: WHO.

# Poorer Women Have a Lower Rate of Skilled Birth Attendance

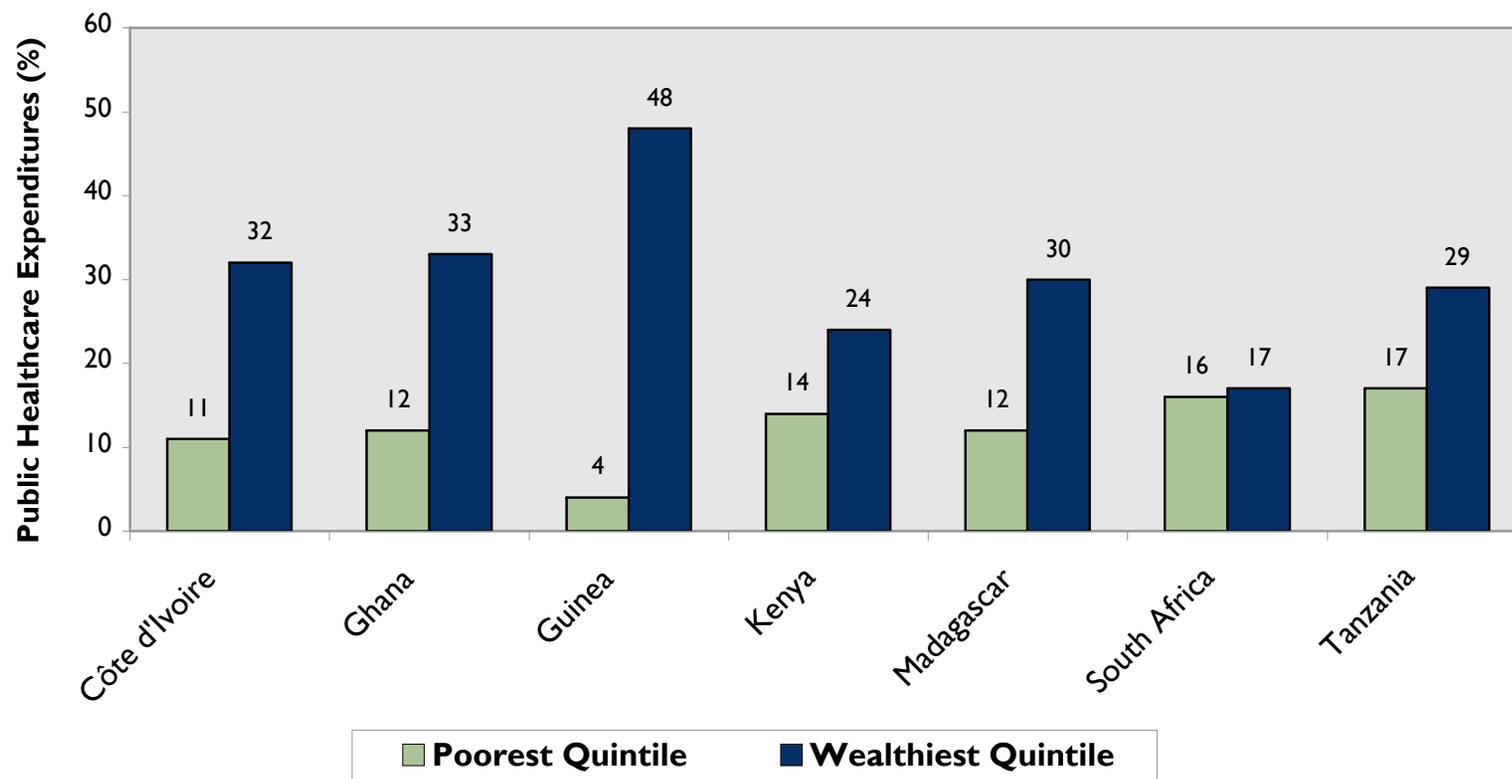
Use of Skilled Health Personnel in Poorest and Wealthiest Quintiles in Nine Countries, 2007



Source: WHO. 2007. *World Health Statistics 2007*. Geneva: WHO.

# Public Sector Resources Are Less Likely to Reach the Poor

**Distribution of Government Healthcare Expenditures Allocated to the Poorest and Wealthiest Quintiles, 2000**



Source: Diderichsen, Finn. 2004. *Resource Allocation for Health Equity: Issues and Methods*. Washington, DC: The World Bank.

# Designing Pro-Poor Policies

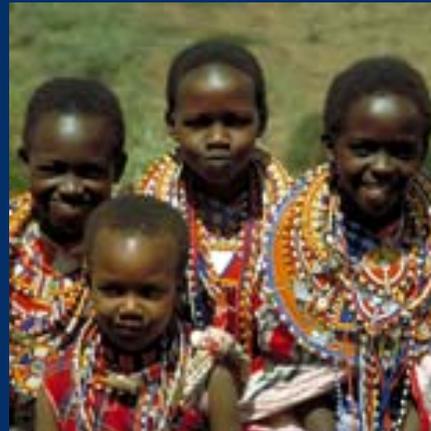


Photo credits:

Indigenous people. © 1995 Corel Corporation | Maasai children, Rift Valley. © 1995 Corel Corporation (Children of the World)

Indigenous people. © 2001 Corbis Corporation

# What Is a Pro-Poor Policy?

- Strategies or interventions focused on benefiting the poor
- Should take into account other social factors that may be associated with poverty (ethnicity, gender, etc.)
- Usually (but not necessarily) involves additional resources for the poor
  - Redistributing existing resources from better-off populations/areas to the poorer populations/areas
  - Adding new resources to specifically target benefits to the poor

# Issues to Consider in a Pro-Poor Policy

- Promoting one sector (e.g., public outlets) will usually have effects on remaining sectors (private and nongovernmental).
- The pro-poor policy should be tailored to the particular goods or services needed. Many poor users of goods and services may be able to pay for cheaper commodities (pills or condoms) but unable to pay for more expensive services (such as intrauterine devices or implants).
- There may be barriers to address, such as ability to pay and/or availability of services, language, class discrimination, and/or other social factors that are equally or even more important.

# Jordan: Quality Improvements Attracted Poor Clients to Government Facilities

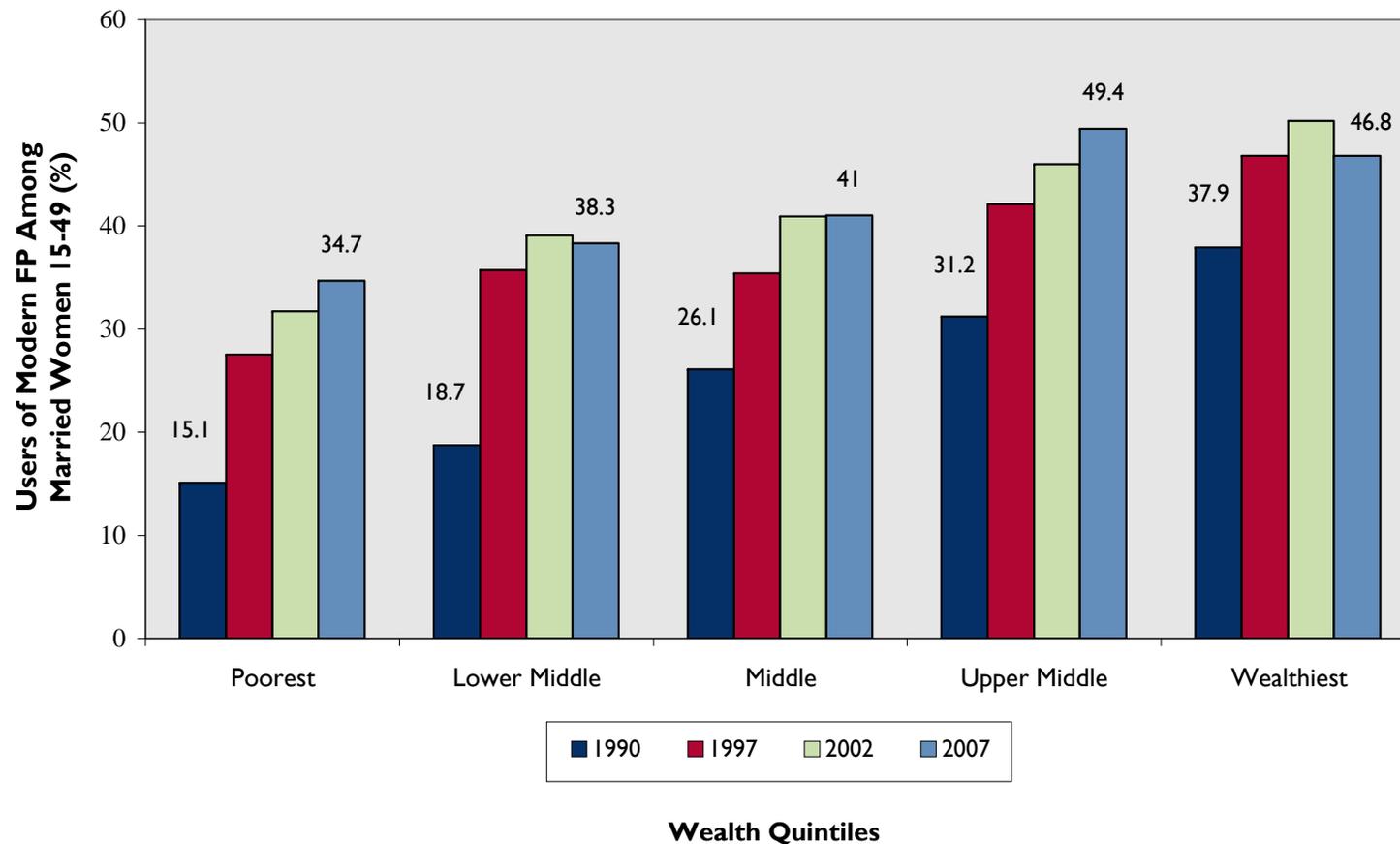
- Ministry of Health targeted efforts to increase access to free and high-quality services in rural and underserved areas
  - Renovated and upgraded public sector facilities
  - Targeted communication activities to the poor
  - Strengthened logistics system



Photo credit:  
Portrait of a Jordanian girl.  
© 1995 Corel Corporation  
(Children of the World)

# Jordan: Increased Modern Contraceptive Prevalence Rates (MCPRs) among the Poor

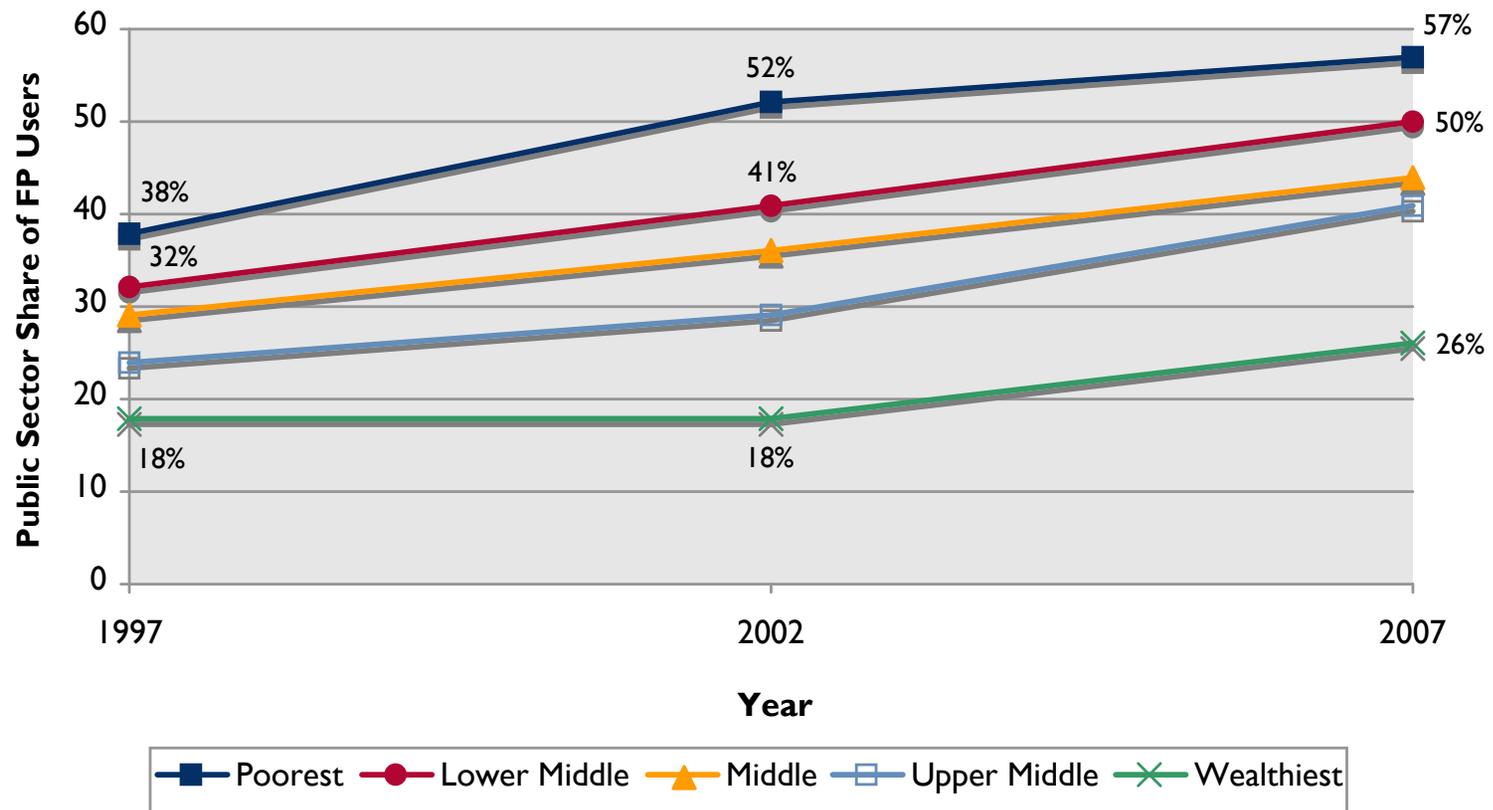
MCPRs among Married Women in Jordan, 1990–2007



Source: Sharma, S., T. Pandit-Rajani, R. Sanders, A. Krishna, and I. Almasarweh. 2009. *A Trend Analysis of the Family Planning Market in Jordan: Informing Policy and Program Planning*. Amman: Futures Group, Health Policy Initiative, Task Order I.

# Jordan: Increased Proportion of Public Sector Family Planning (FP) Services Provided to the Poor

## Proportion of FP Services Provided by the Public Sector, Jordan, 1997-2007



Source: Sharma, S., and K. Mahesh. 2009. Effective Policy Approaches to Address Inequities in Health: Examples from Jordan and Egypt. IUSSP Health Equity Conference Paper, November 2-4.

# Egypt: Effective Outreach Attracted Poor Clients to the Public Sector

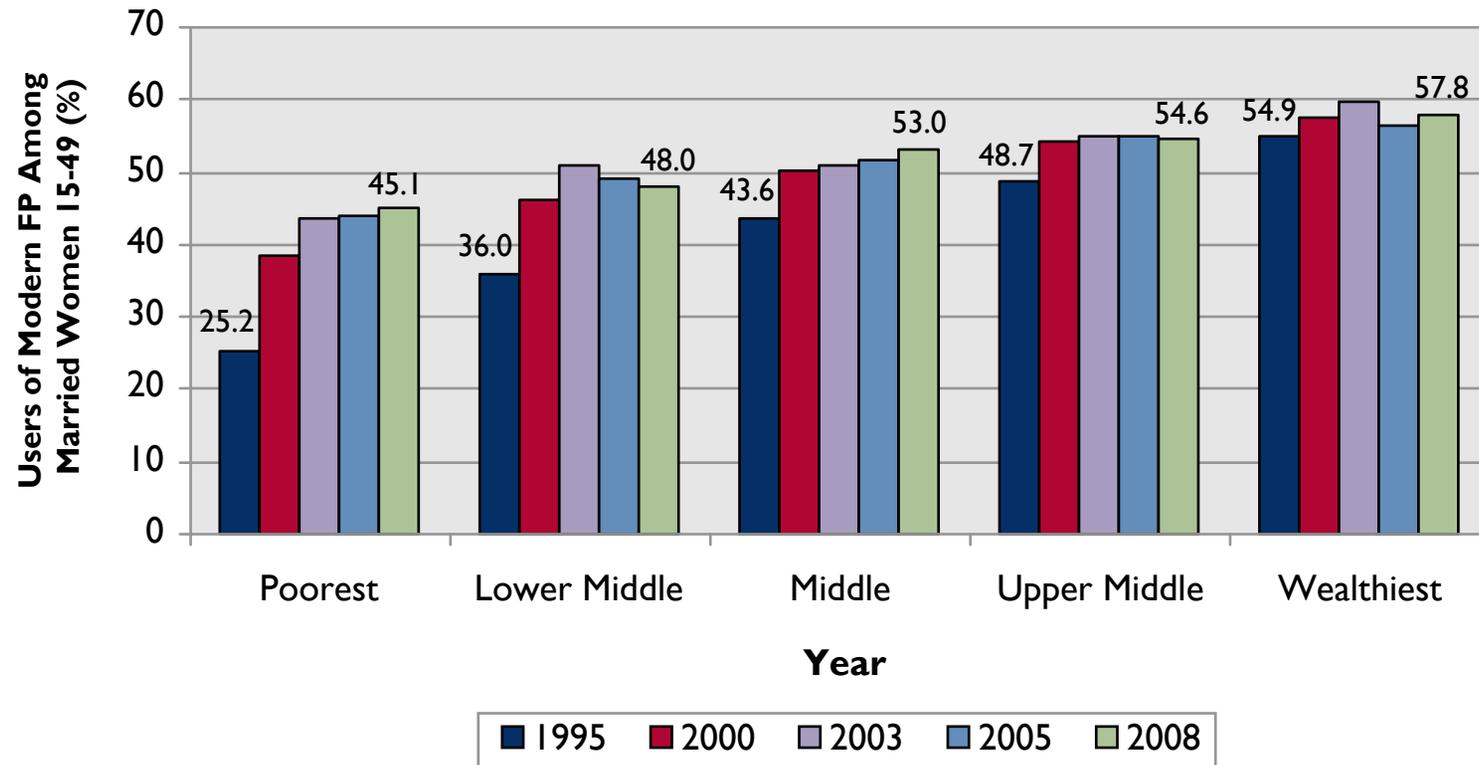


Photo credit: ©iStockphoto.com/Damir Cudic

- Increased outreach, media campaigns, and services to target poor clients
- Increased availability of free contraceptives
- Targeted pricing and positioning patterns in public, nongovernmental, and commercial sectors, encouraging poor clients to use outlets according to their ability to pay

# Egypt: Increased MCPRs among the Poor

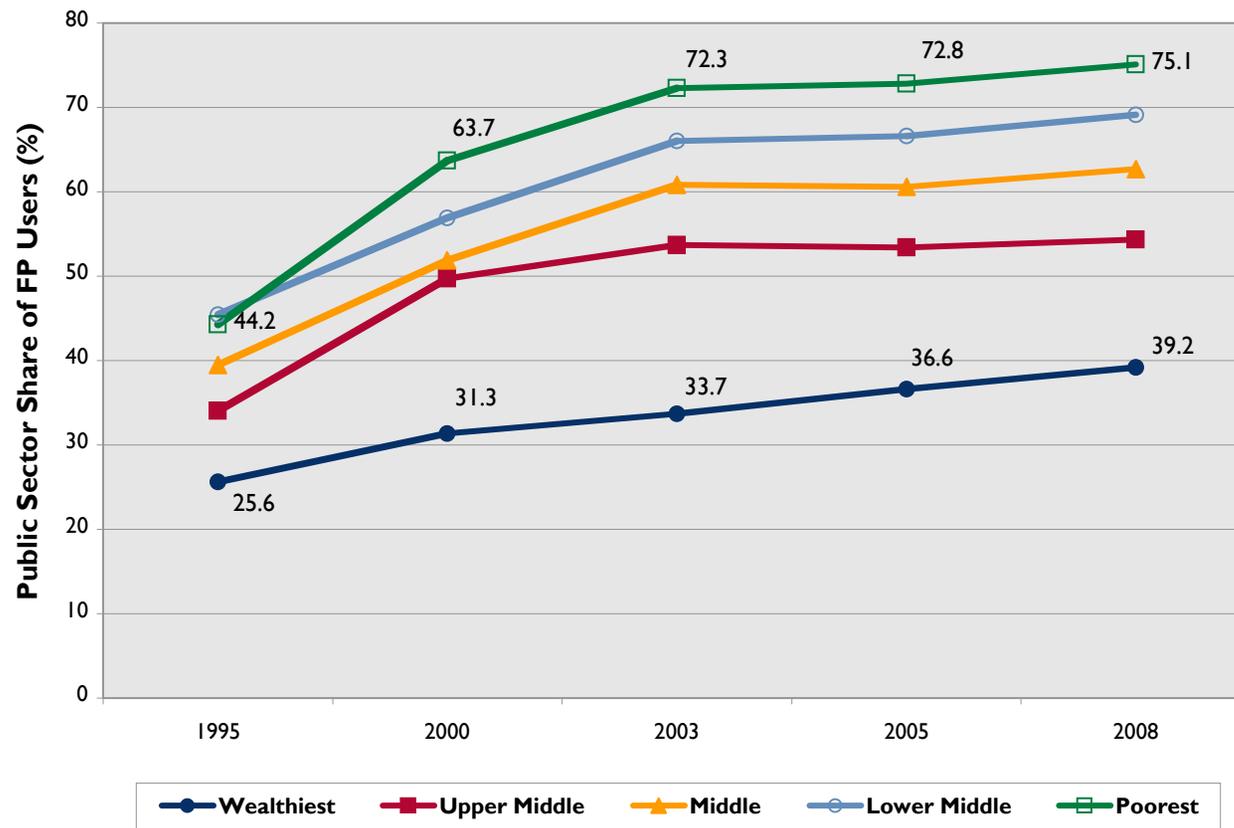
Use of Modern Family Planning among Married Women Ages 15–49, Egypt, 1995–2008



Source: Sharma, S., and K. Mahesh. 2009. Effective Policy Approaches to Address Inequities in Health: Examples from Jordan and Egypt. IUSSP Health Equity Conference Paper, November 2–4.

# Egypt: Increased Dependence on the Public Sector by the Poor

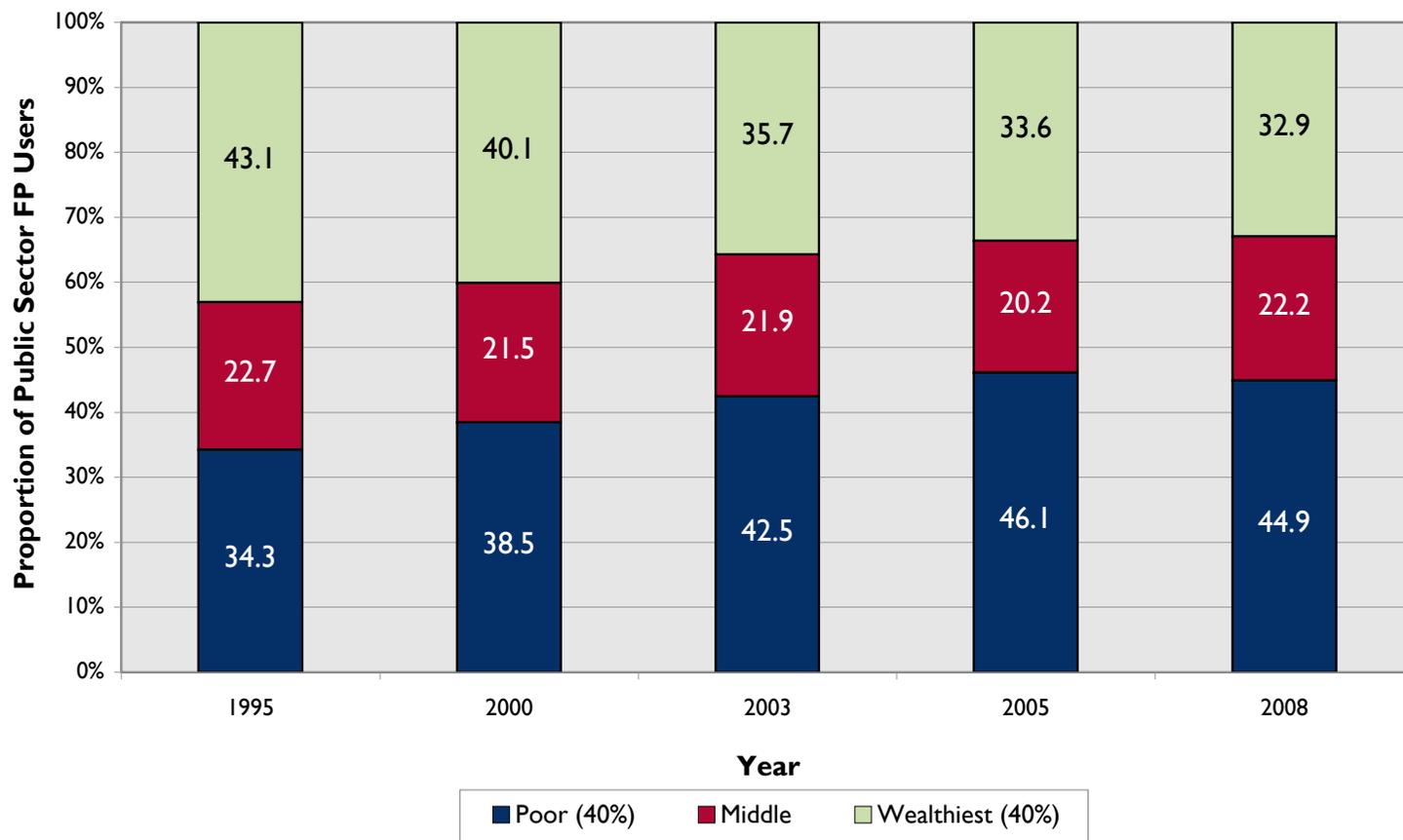
Proportion of FP Services Provided by the Public Sector, 1995–2008



Source: Sharma, S., and K. Mahesh. 2009. Effective Policy Approaches to Address Inequities in Health: Examples from Jordan and Egypt. IUSSP Health Equity Conference Paper, November 2–4.

# Egypt: Result: Positive Trends in Egypt's Pro-Poor Strategy, 1995 to 2007

Public Sector Client Profile, Egypt, 1995-2008



Source: Egypt Demographic and Health Survey (DHS) (various years).

# Policy Approaches to Achieve **EQUITY** in Healthcare Use and Outcomes

**E**ngage and empower the poor

**Q**uantify the level of inequality in healthcare use and health status

**U**nderstand **all** the barriers to access

**I**ntegrate equity goals and approaches in policies, plans, & agendas

**T**arget resources and efforts to the poor

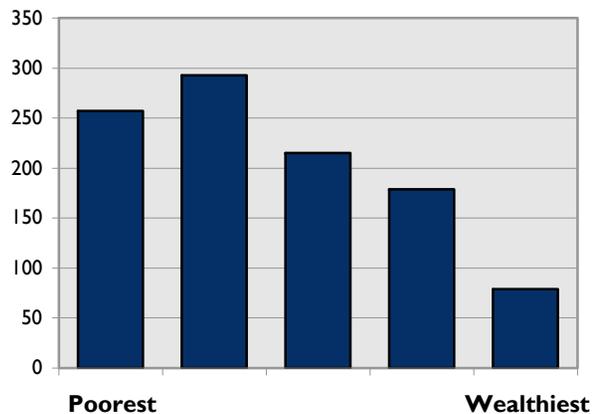
**Y**ield public-private partnerships for equity

# Engage and Empower the Poor

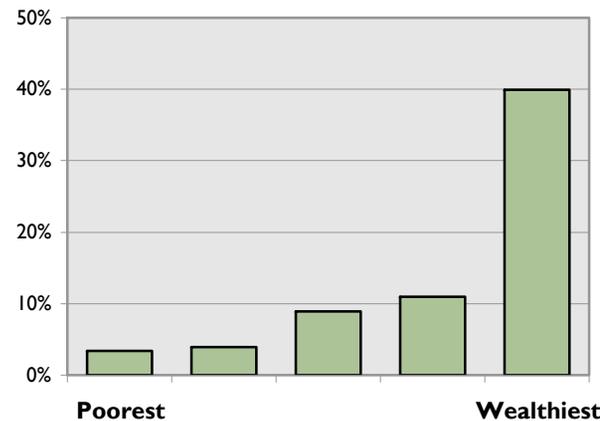
Policy, program, and implementation decisions affecting the poor should be made with the poor, not for the poor

- Who is poor?
- What are the consequences of being poor?
- What are the reasons for low use of healthcare services or poor health outcomes among the poor?
- What are some practical and effective solutions to improve the situation?
- How can we make policymakers and providers more accountable for achieving pro-poor results?

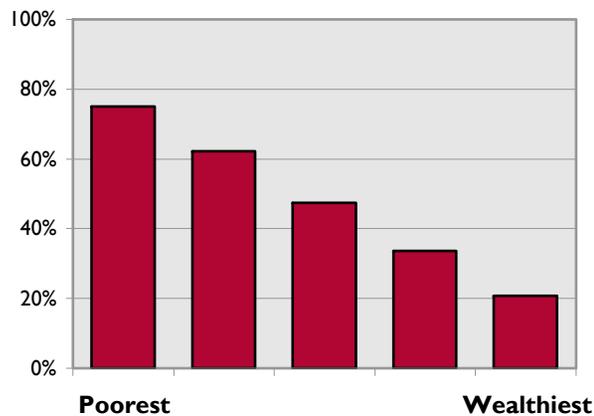
# Quantify the Level of Inequality in Healthcare Use and Health Status



Under-5 mortality rate in Nigeria



% children fully vaccinated in Nigeria



% of women reporting at least one "big" problem in accessing healthcare in Nigeria

Source: Nigeria DHS 2003.

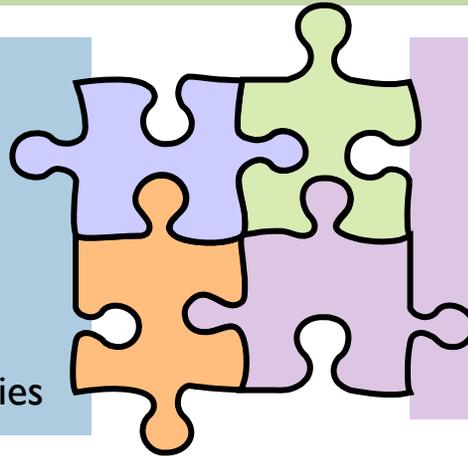
# Understand All the Barriers to Access

## Policy

- Political Commitment
- Development Programs and Agendas
- Policy Direction
- Engagement of Civil Society

## Supply-Side

- Hours of Operation
- Waiting Time
- Provider Behavior
- User Fees/Informal Charges
- Availability of Staff
- Availability of Commodities/Supplies



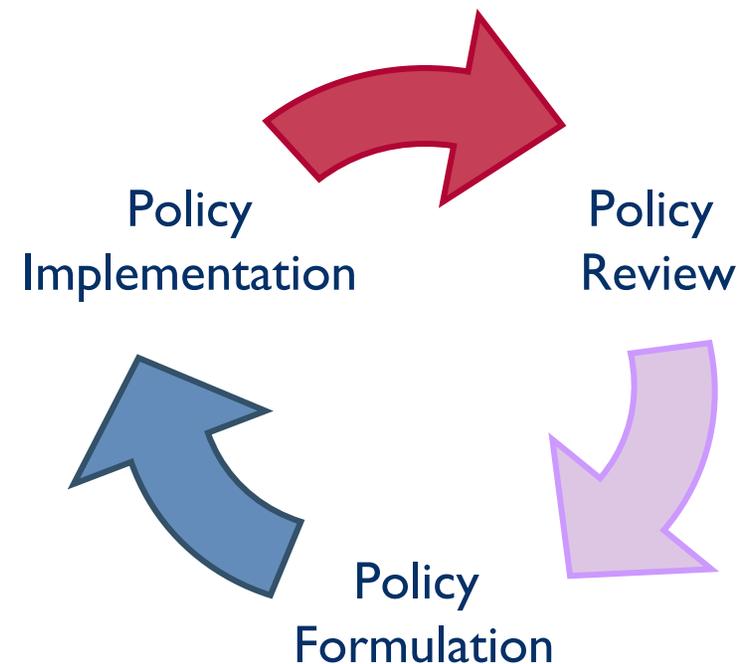
## Demand-Side

- Male Involvement
- Cost of Transportation
- Cultural and Religious Beliefs
- Access to Household Resources
- Physical Access

Low access among the poor  
Differences in healthcare use and status are  
**avoidable and unfair.**

# Integrate Equity Goals and Approaches in Policies, Plans, & Agendas

- Set goals for improved coverage and health outcomes among the poor
- Link population/health and development
- Design strategies to achieve the stated equity goals
- Ensure equity-based monitoring
- Empower poor clients to ensure accountability



# Target Resources and Efforts to the Poor



- **Design targeted interventions for**
  - Poverty pockets
  - Slums
  - Underserved regions
- **Design and implement interventions for target groups**
  - Urban poor
  - Rural poor
  - Indigenous people
  - Refugees

# Yield Public-Private Partnerships for Equity

- The private sector is already providing healthcare services to the poor and non-poor.
- Greater involvement of the private sector can free up donor and government resources for the poor.
- Private sector participation has untapped potential.



# The Policy Approach Has Achieved Results!

## **Session 3: E**ngaging and Empowering the Poor

(Guatemala, India, Kenya, Nigeria, Peru, and Romania)

## **Session 4: Q**uantifying the Level of Inequality in Healthcare Use and Health Status

(global and regional)

## **Session 5: U**nderstanding the Barriers to Access

(video illustrating examples from the Kenyan poor)

## **Session 6: I**ntegrating Equity Goals and Approaches in Policies, Plans, & Agendas

(Kenya, Mali, and Rwanda)

## **Session 7: T**argeting Resources and Efforts to the Poor

(India, Peru, and Latin America and the Caribbean / Africa region)

## **Session 8: Y**ielding Public-Private Partnerships for Equity (India)

## **Session 9: M**easuring Success and Informing Scale-Up