Activities at regional level to address social determinants and health inequalities

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WHO Seminar

Malé

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Outline

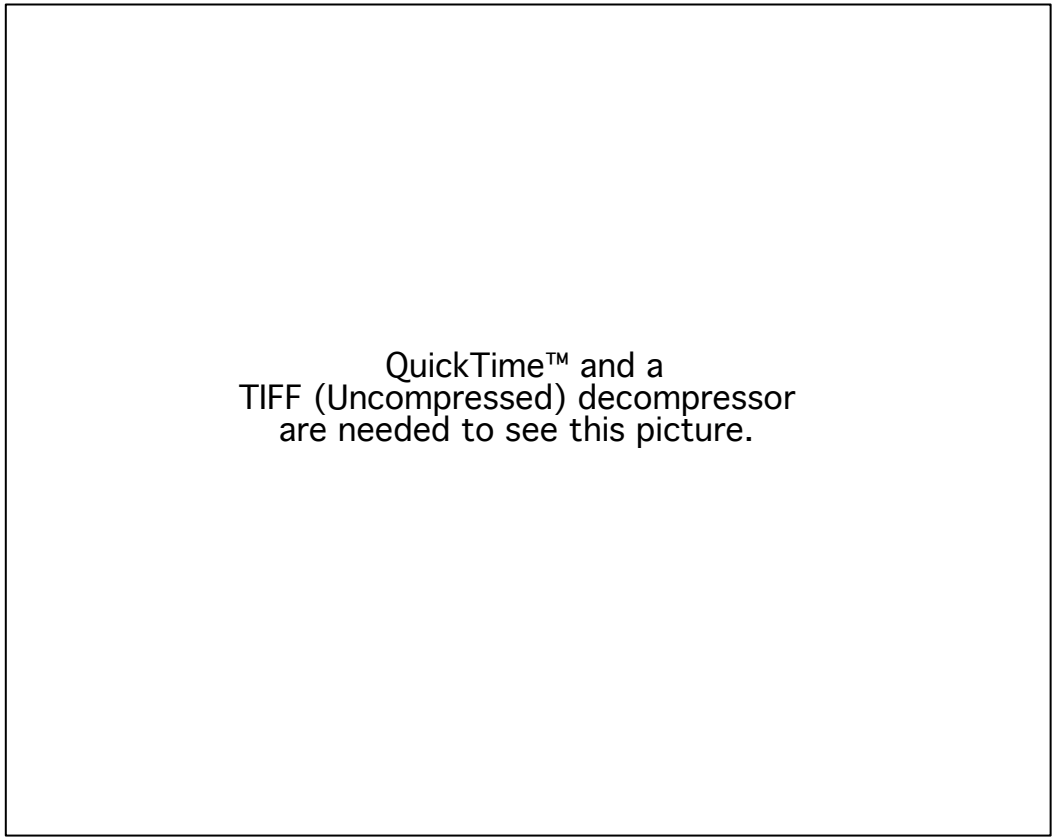
- Monitoring and understanding health systems inequities
  - The Equitap network
  - Impact of health systems
- Social Determinants of MNCH
  - WHO SEARO Regional Study & Findings

The Equitap Collaboration

"Equity in Asia-Pacific Health Systems"

Equitap Research Collaboration

- Collaborative research partnership conceived, initiated and coordinated by Asia-Pacific NHA Network in 2001 to examine equity in health systems
- Research centres in Bangladesh, Nepal, India, Sri Lanka, Thailand, Philippines, Indonesia, Malaysia, China, Kyrgyz, Mongolia, Taiwan, Hong Kong SAR, Korea, Japan, Laos, Cambodia, Vietnam…
- Established with technical input from European health equity network, but now independent Currently expanding to Mekong and South Pacific



Equitap 1 Equitap 2 expansion

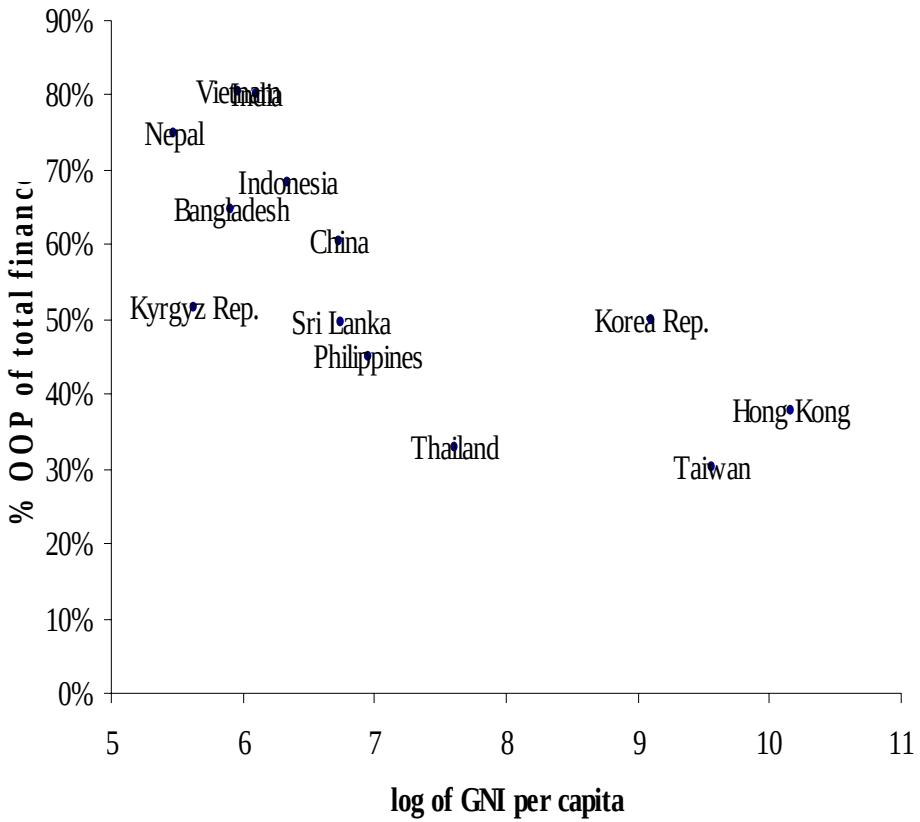
Equitap Research - Measuring and understanding health systems equity

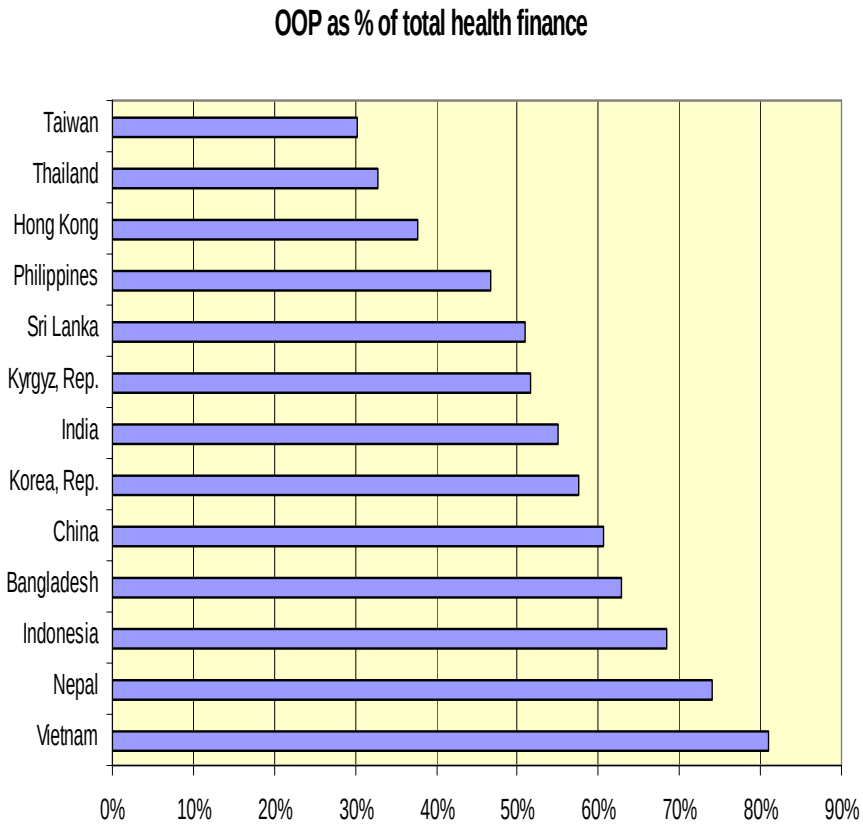
Research components

- Profiling health financing using health accounts
- Measuring distribution of payments for health care
  - Taxation, social health insurance, out-of-pocket payments
- Assessing targeting of government health spending
  - Benefit incidence
- Risk protection in health systems
  - Incidence of catastrophic health spending
- Health outcomes
  - Adult and child health inequalities
- Explaining health systems inequalities

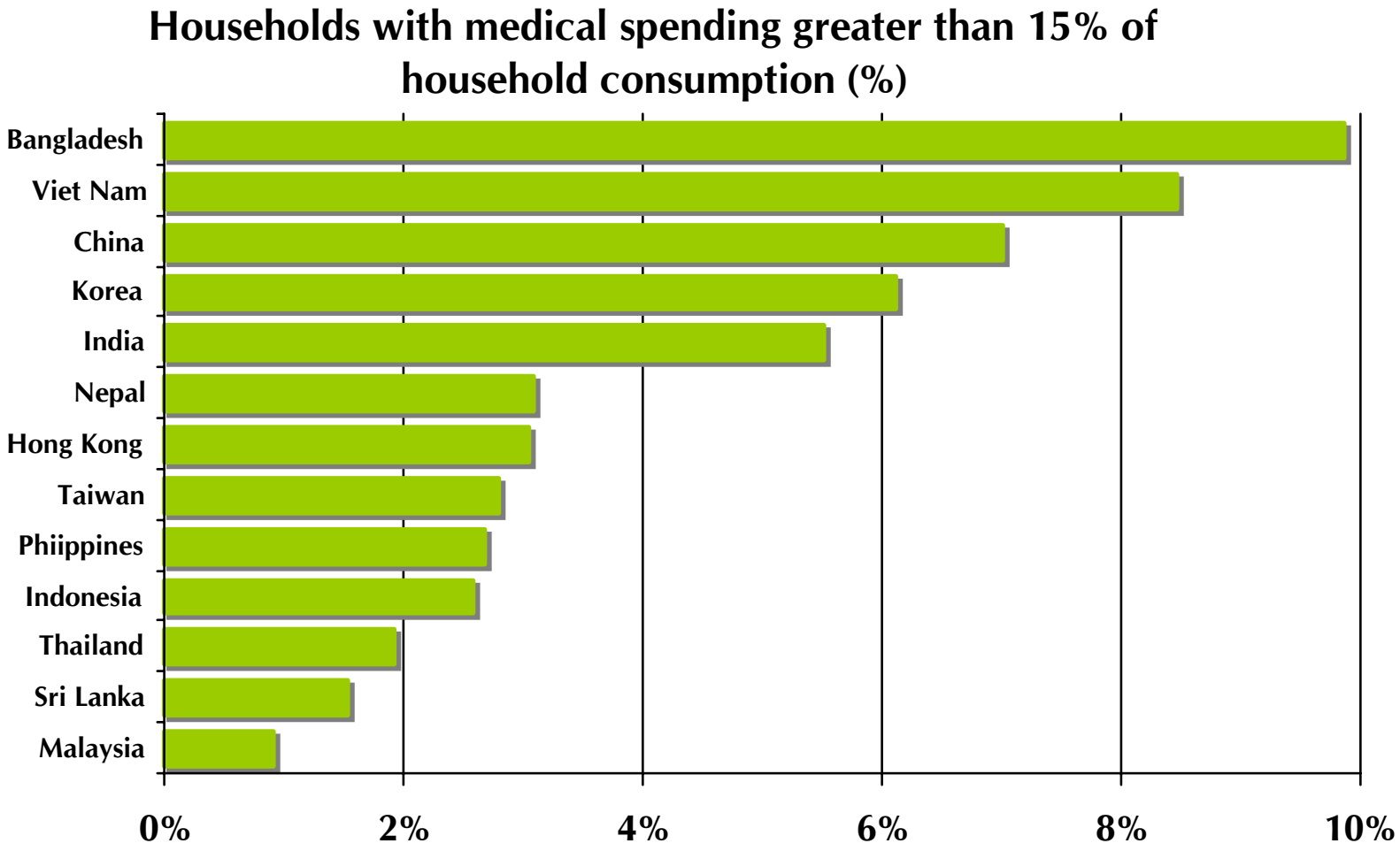
Selected Findings from Equitap

Out-of-pocket payments

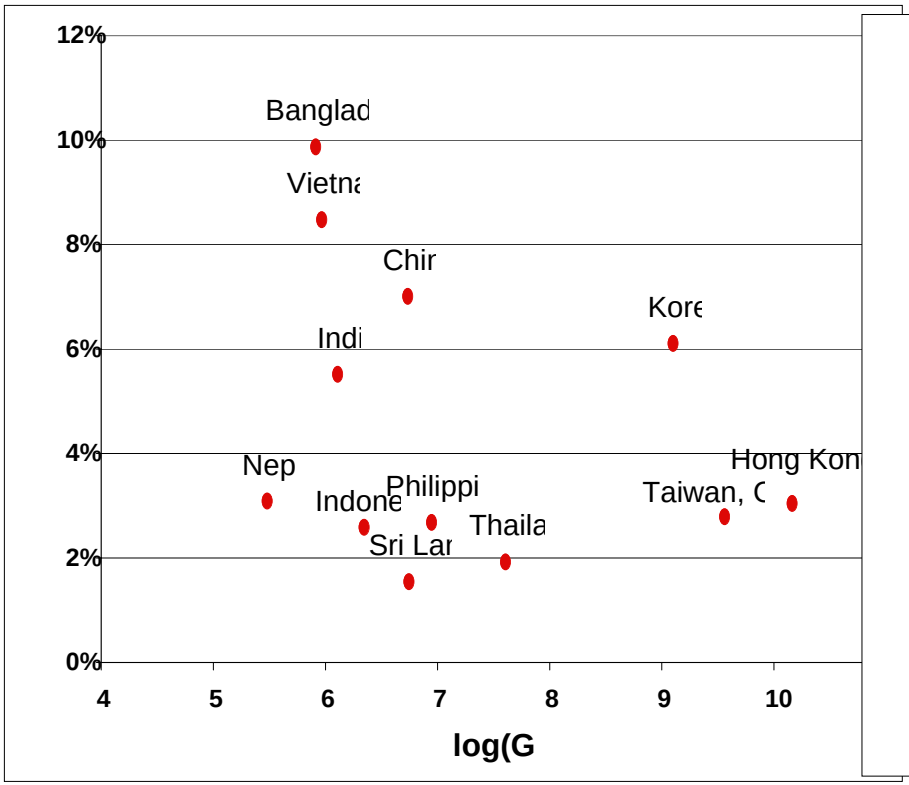


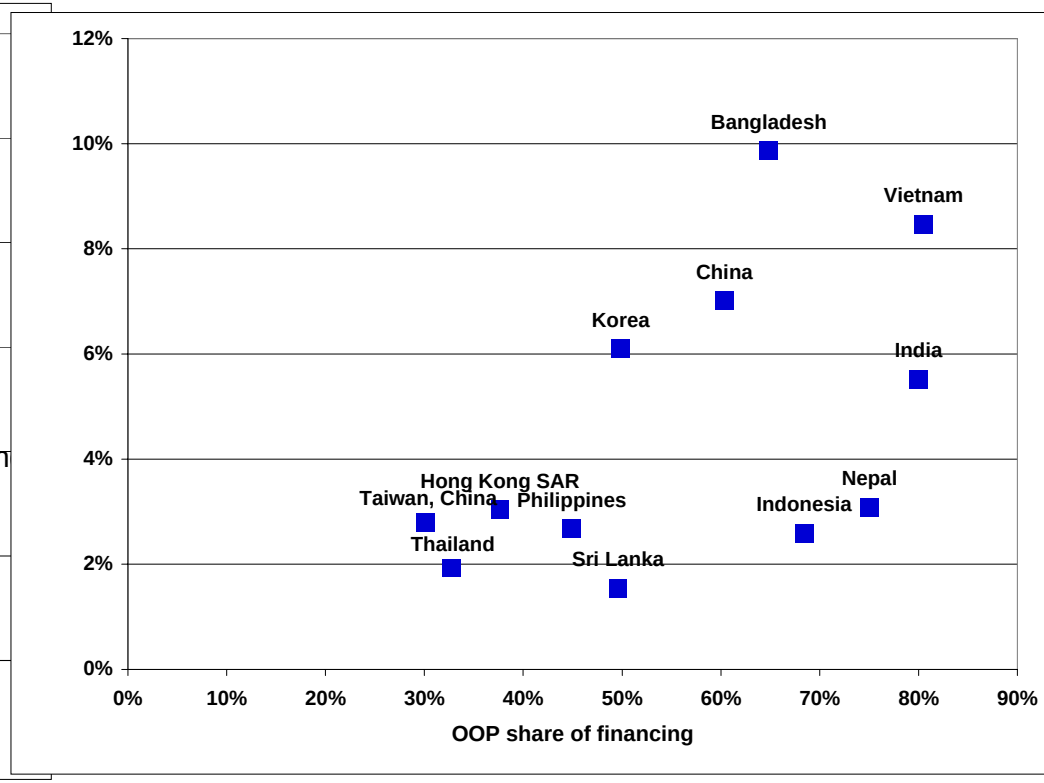


Catastrophic impacts

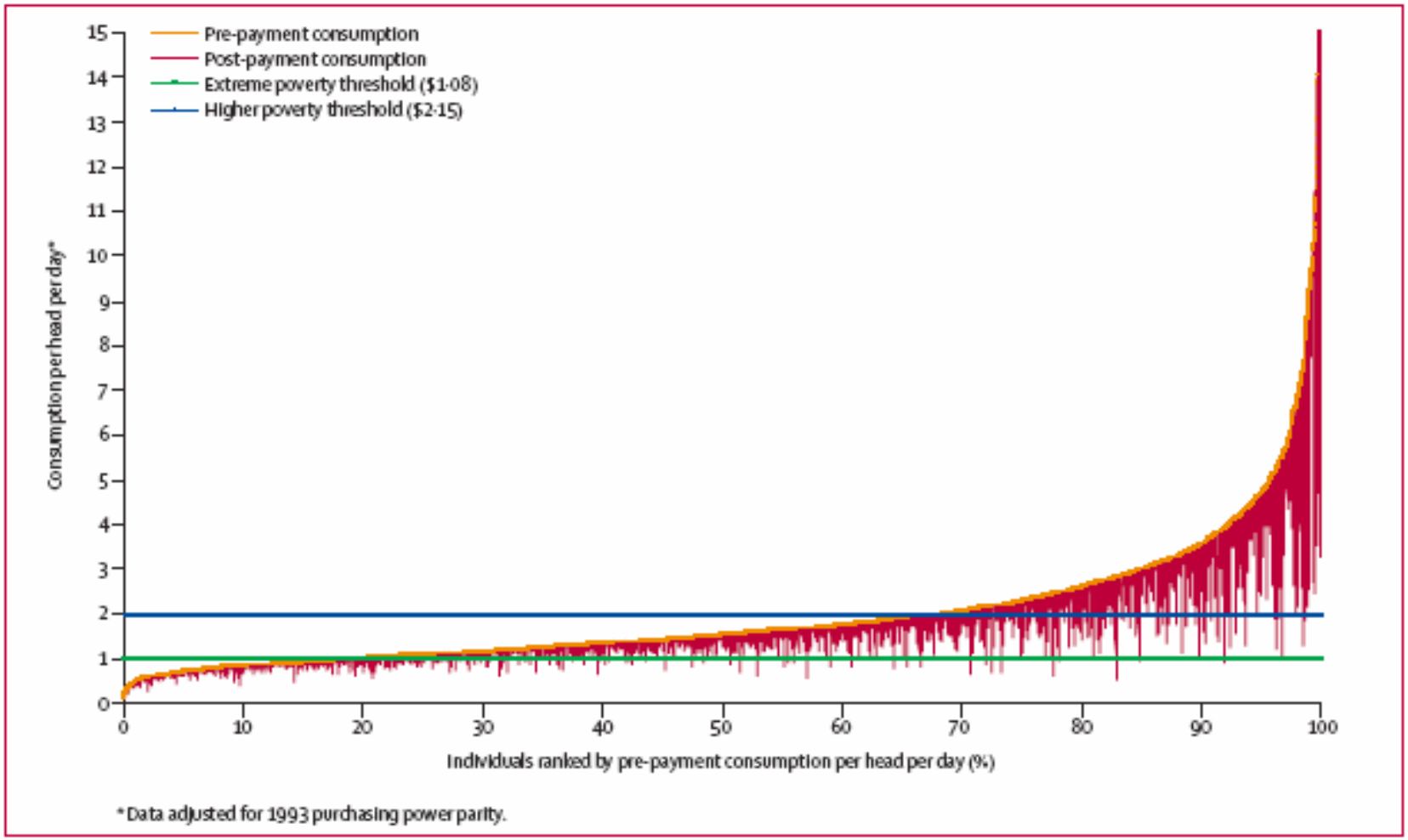


Correlates of financial catastrophe





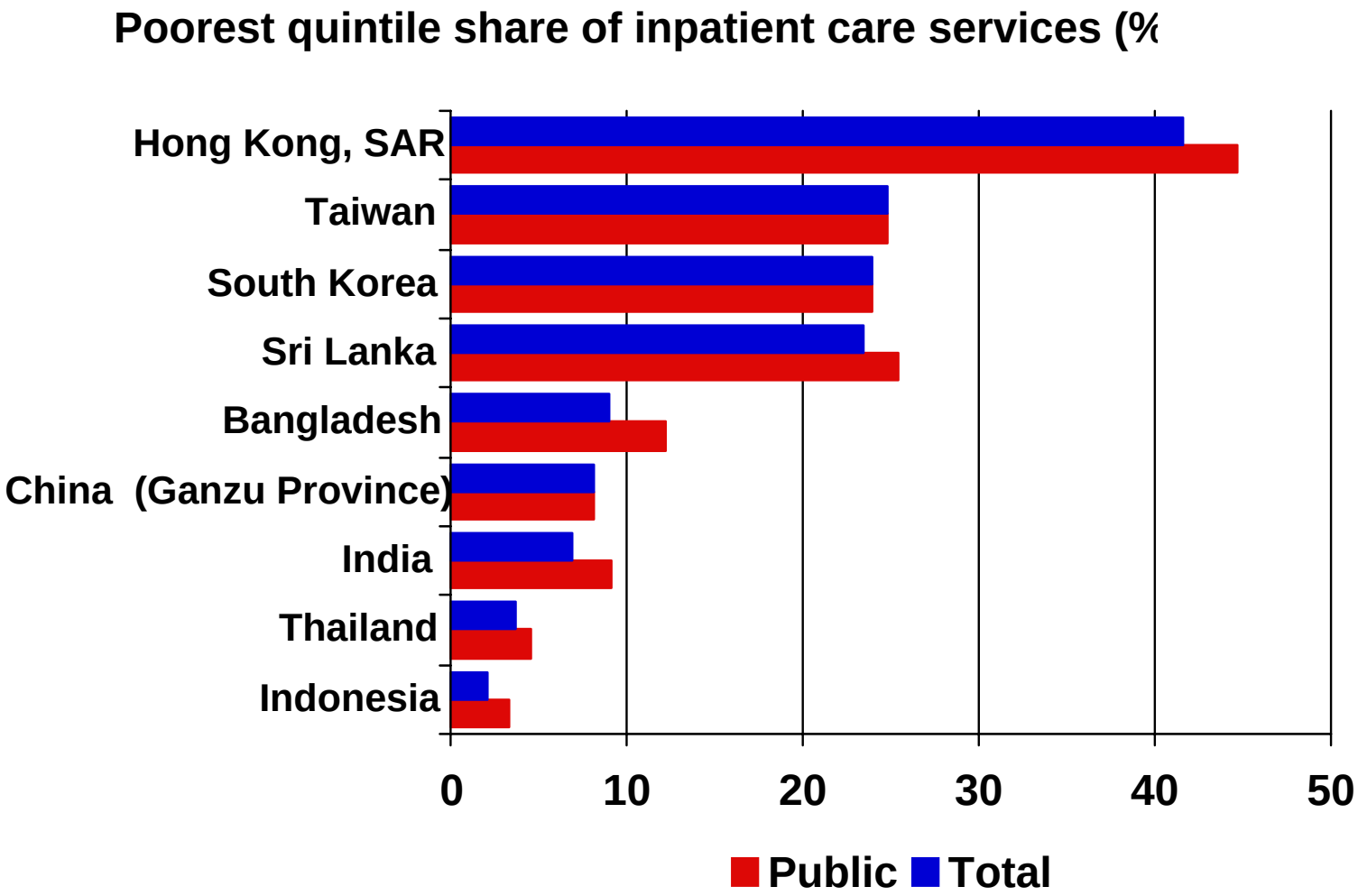
Poverty impact of health OOPs on Pen Parade in Bangladesh (US$1.08 poverty line)



*Data adjusted for 1993 purchasing power parity.

Figure 3: Distribution of total consumption before and after subtracting health-care payments–Bangladesh (2000)

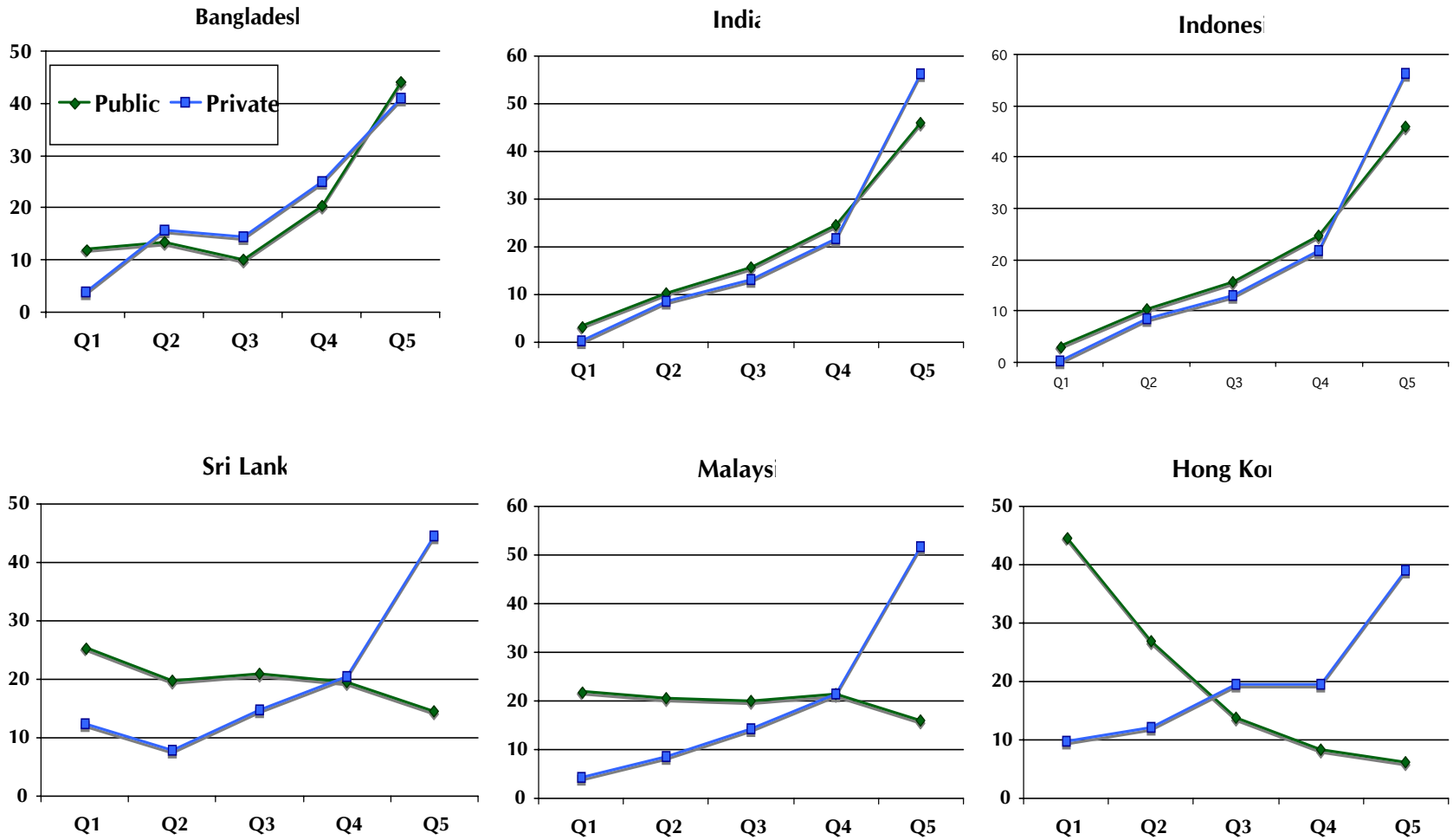
Targeting & use disparities



Who benefits from public subsidies?

- Public subsidies for health are
  - strongly pro-poor in Hong Kong SAR (China)
  - moderately pro-poor in Malaysia, Sri Lanka, Thailand and Mongolia
  - pro-rich in Bangladesh, China, Indonesia and Vietnam
- Pro-rich bias stronger for inpatient than outpatient hospital care; non-hospital care is usually pro-poor.
- … but greatest share of subsidy goes to hospital care and this dominates distribution of total subsidy.
- Subsidies typically not pro-poor but are inequality-reducing in all countries except in Nepal:
- Health subsidies narrow relative differences in living standards b/w rich and poor.

Explaining why some countries target government health services well



Performance of health systems

Universalistic, tax-funded systems No/minimal user fees, no explicit targeting/voluntary self-selection by rich of private sector, emphasis in spending towards hospitals/inpatient care, high density of supply.	Sri Lanka Malaysia Hong Kong 
Non-universalistic, tax-funded systems User fees, means testing, diverse ineffective experimentation in “reaching the poor” projects, emphasis in spending towards non-hospital care, low density of supply.	Bangladesh Indonesia India Nepal 
National health insurance systems Universal social health insurance, large tax-subsidy for insurance, emphasis in spending towards hospitals/inpatient care	Japan Korea Taiwan (Mongolia/Thailand) 
Transition systems Restricted social health insurance, minimal tax-subsidy for insurance, user charges major mechanism of financing	China Viet Nam 

WHO SEARO Study of Social Determinants of Health in Regional Countries

WHO SEARO Study

Objectives

- To assess inequities in health and access to health services at the country level
- To decompose factors contributing to inequities in health status and health systems indicators
- To provide a regional overview of the socioeconomic distribution of health processes and outcomes

Countries covered

- Bangladesh, India, Nepal, Sri Lanka, Thailand, Indonesia

Approach

- Analysis of household survey data sets using WHO CSDH framework
- Inequalities assessed, then analyzed according to CSDH determinants

Health outcomes examined

Health systems indicators

- DPT3 vaccination coverage
- Skilled birth attendance coverage
- Contraceptive prevalence rate (for all married women)

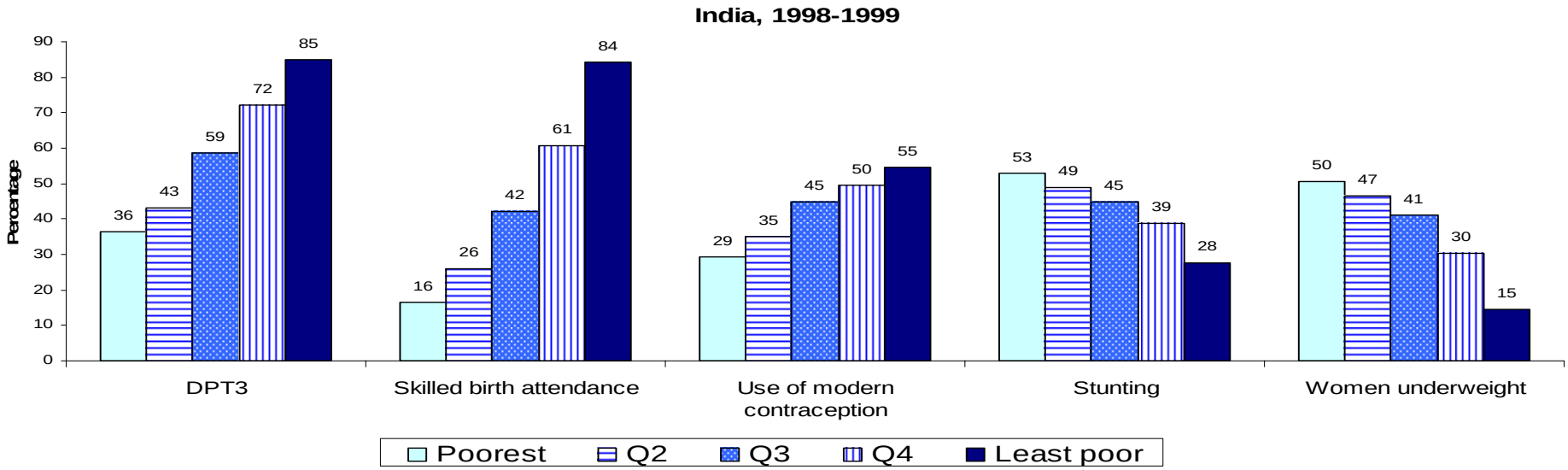
Health outcomes

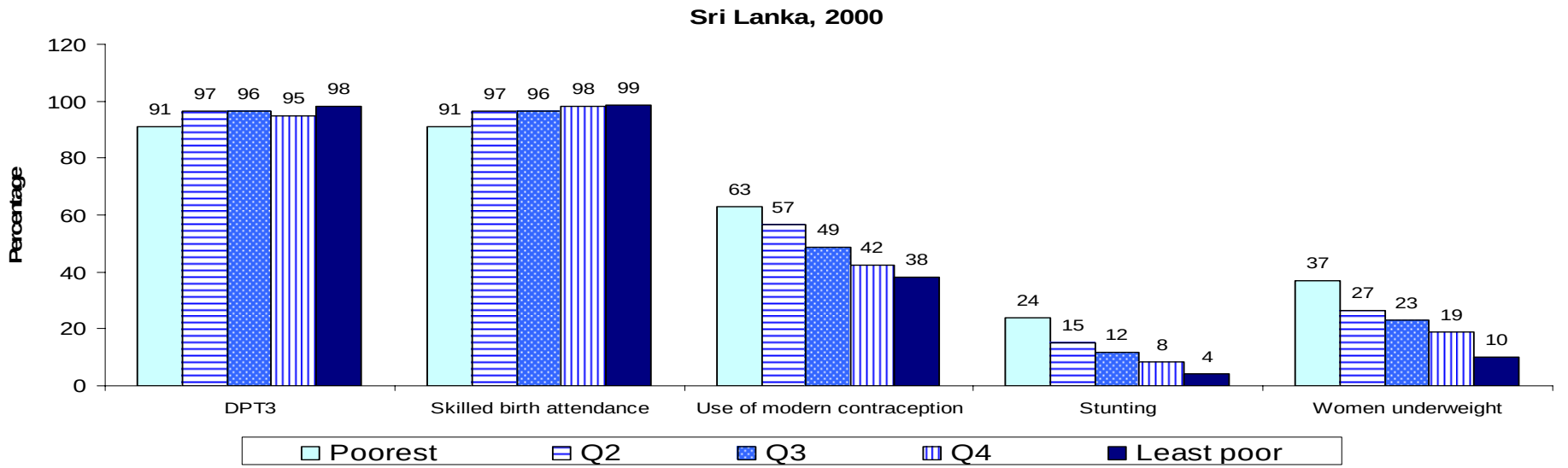
- Infant mortality rate
- Under-five mortality rate
- Stunting in children under five years of age
- Prevalence of underweight in women
- Prevalence of overweight in women

Dimensions analyzed

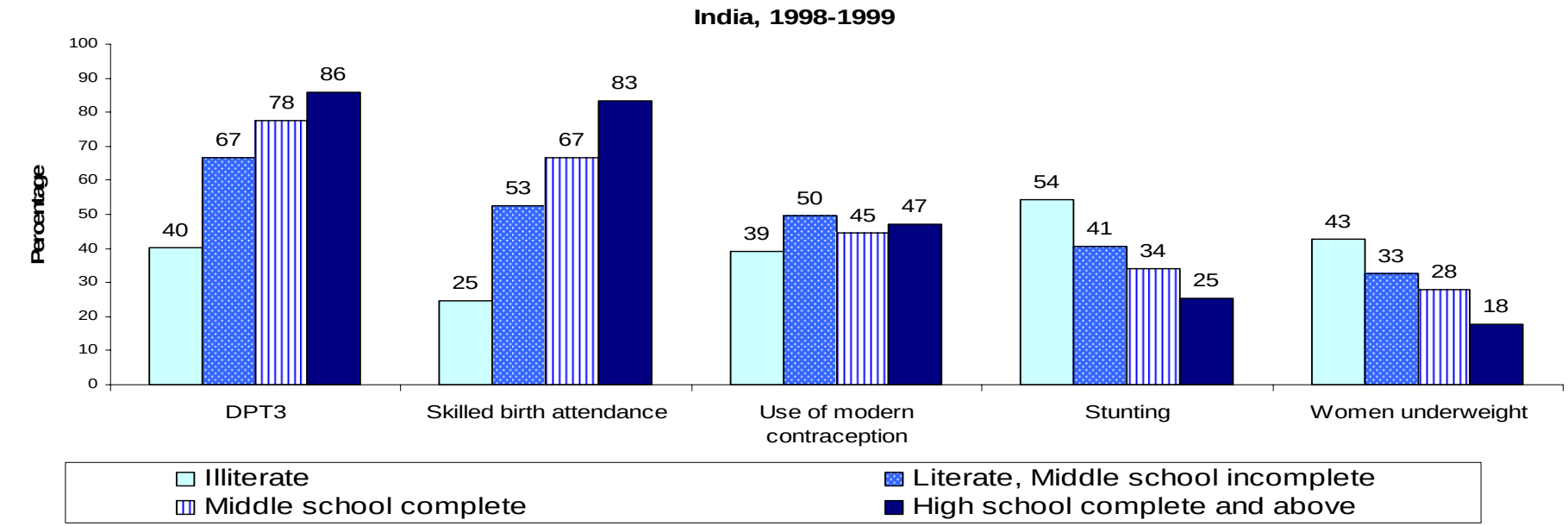
- Sex of child (for IMR and U5R only)
- Urban/rural residence
- Mother's educational attainment
- Household wealth quintile

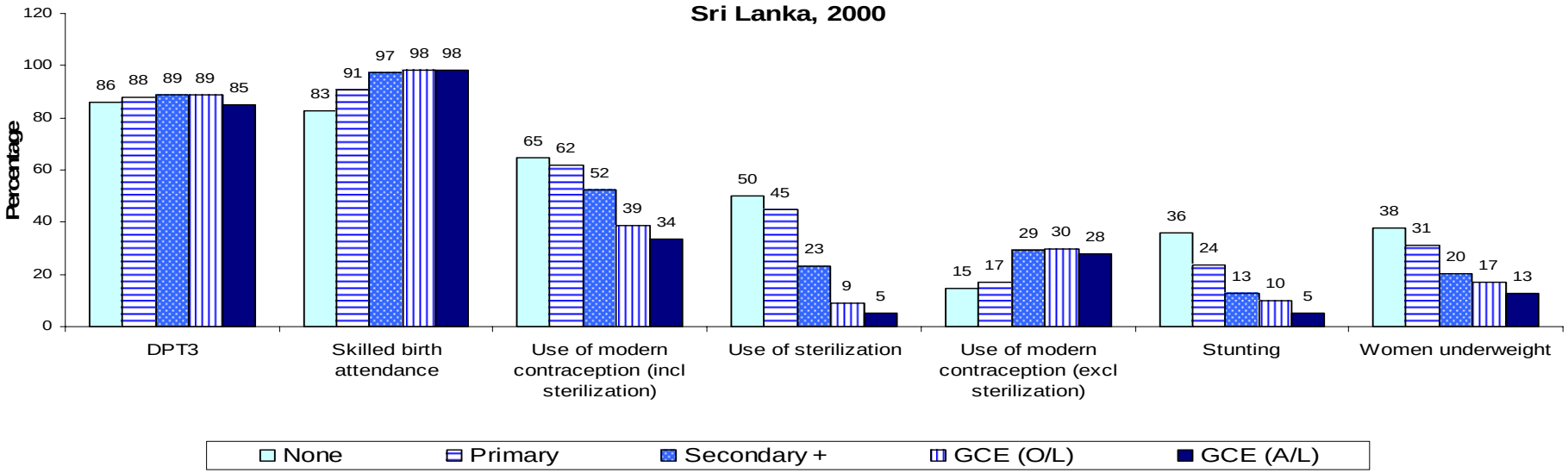
Comparison of Health Indicators by Wealth Quintiles



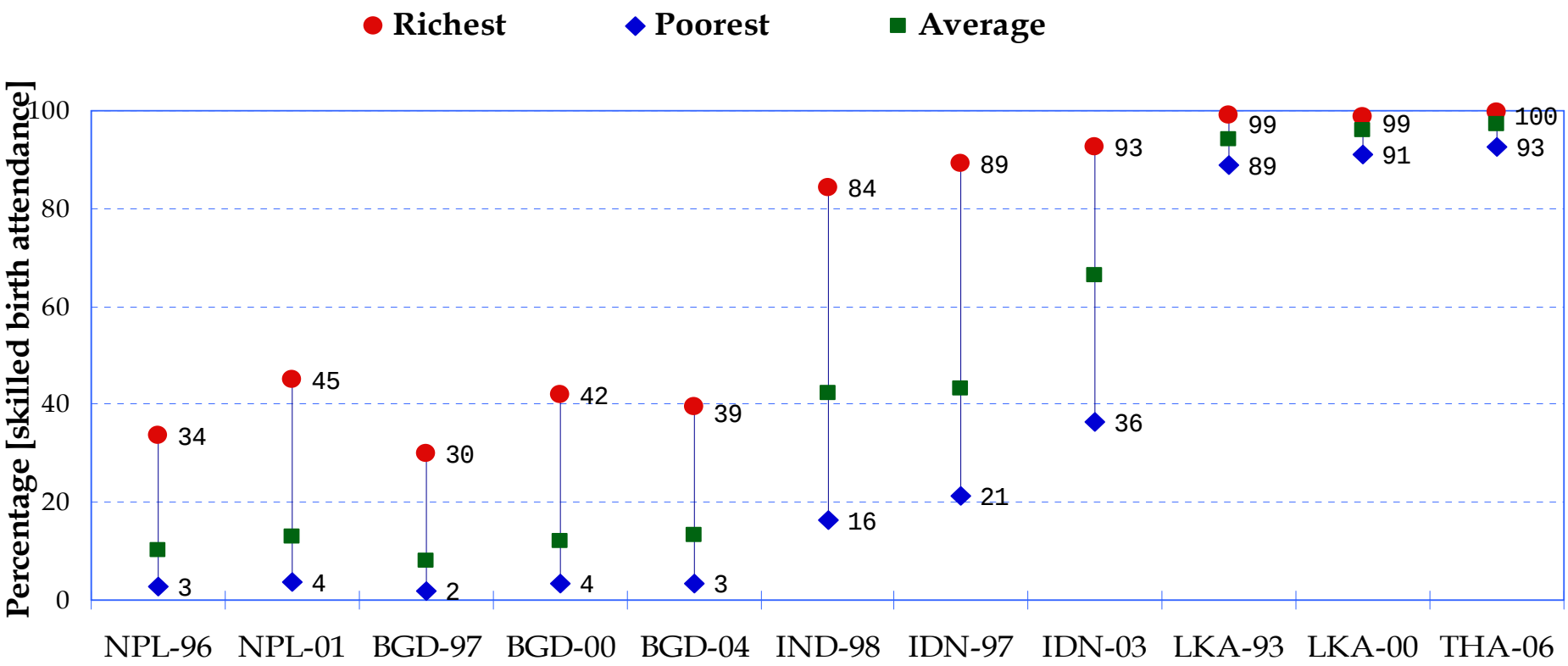


Comparison of Health Indicators by Educational Attainment

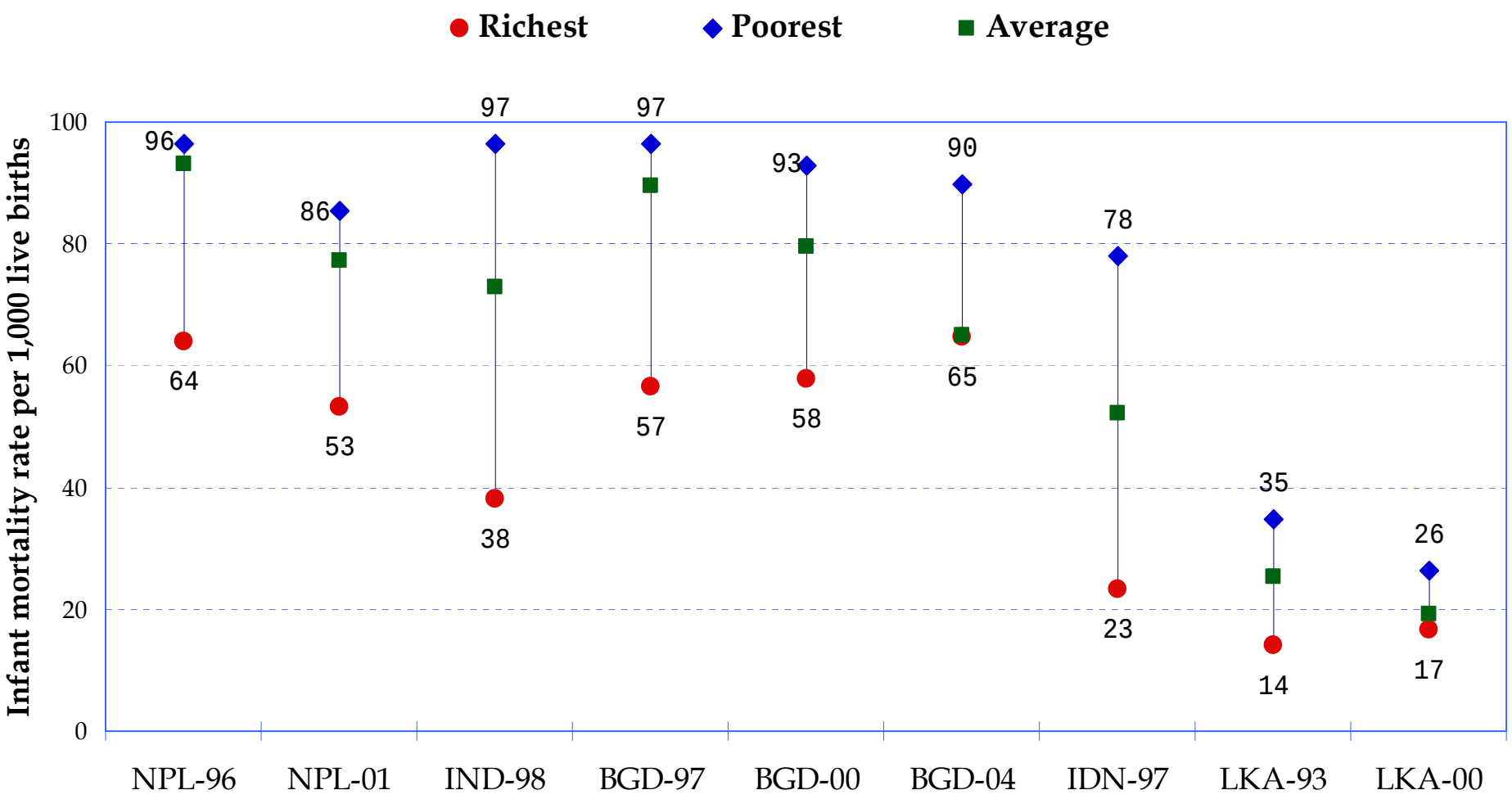




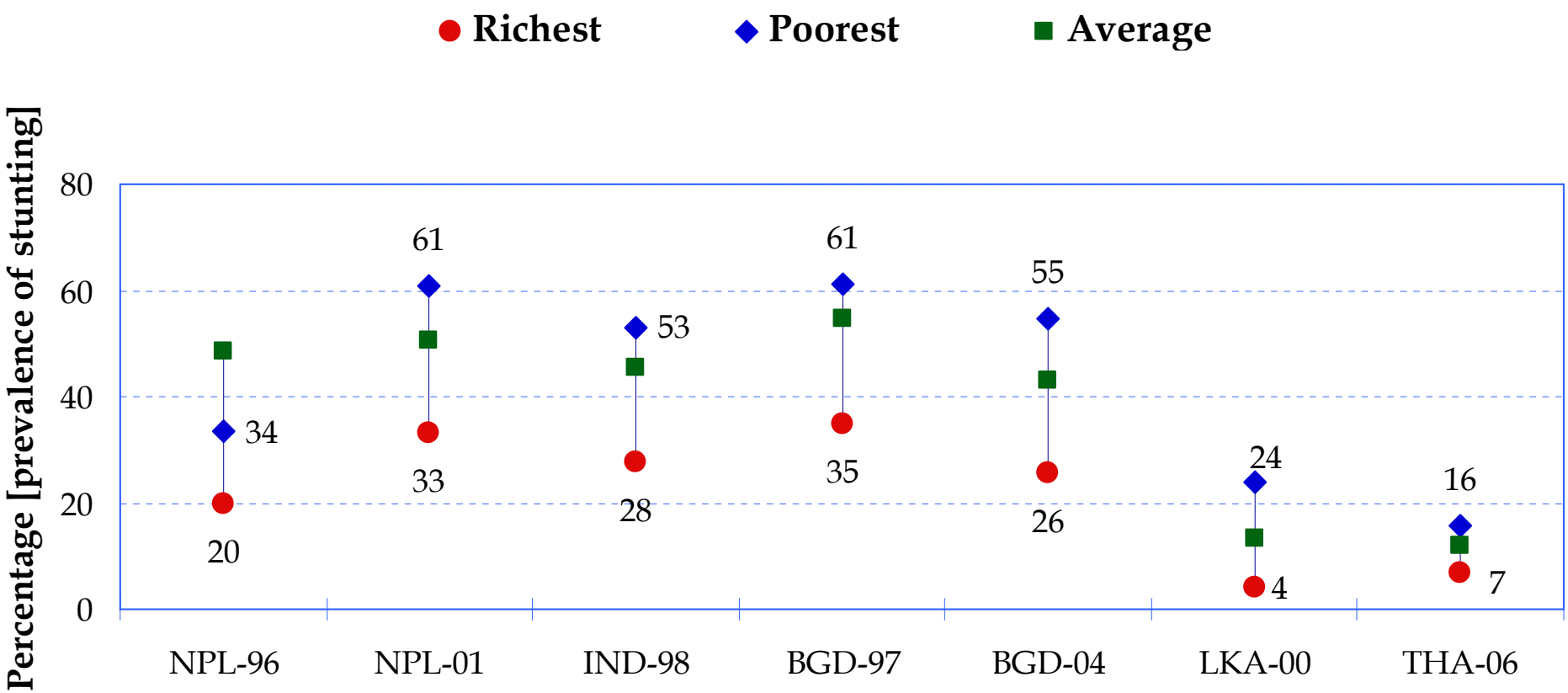
Inequalities in *skilled birth attendance* between the poorest and richest wealth quintiles by country



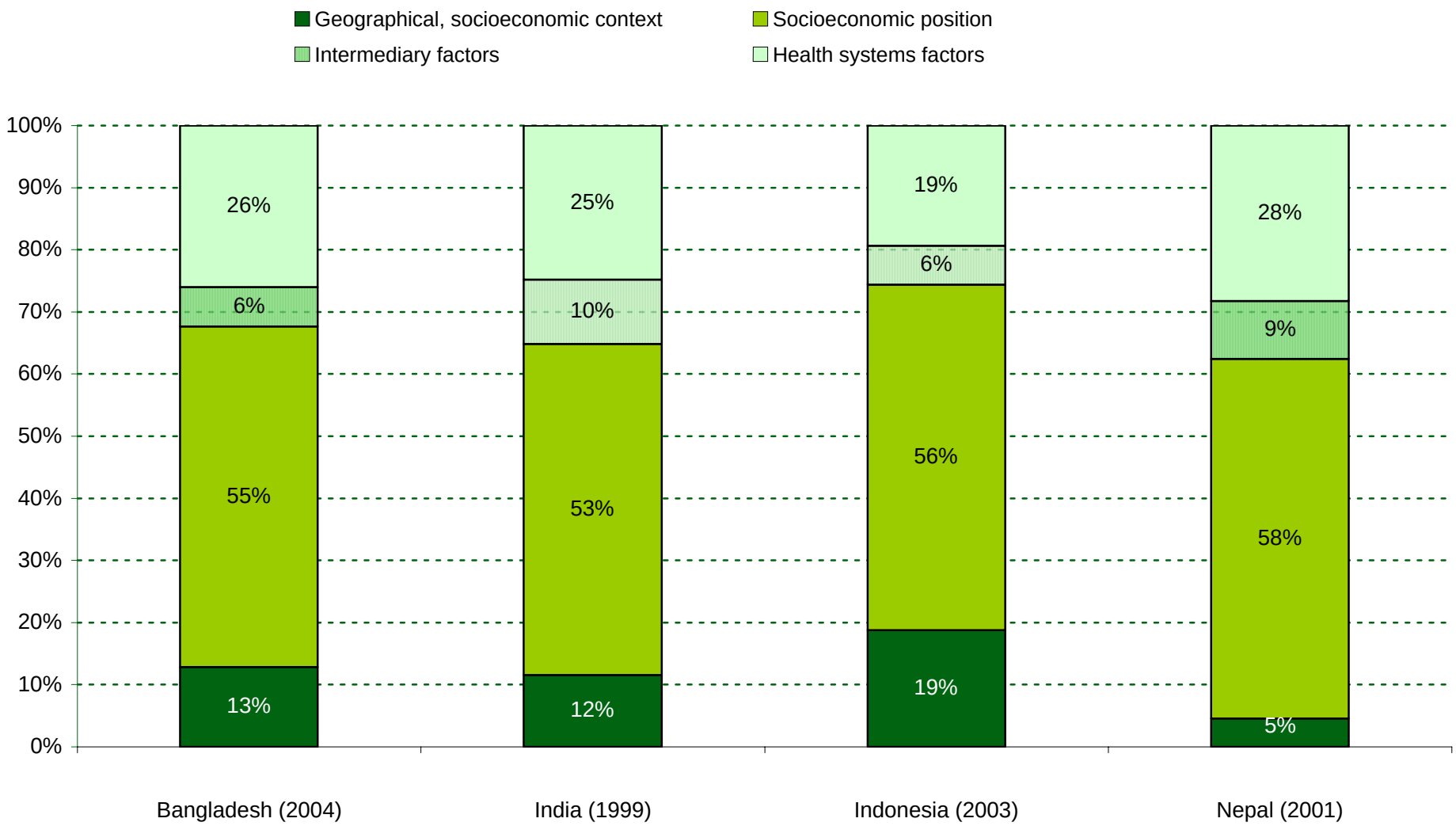
Inequalities in *infant mortality rate* between the poorest and richest wealth quintiles by country



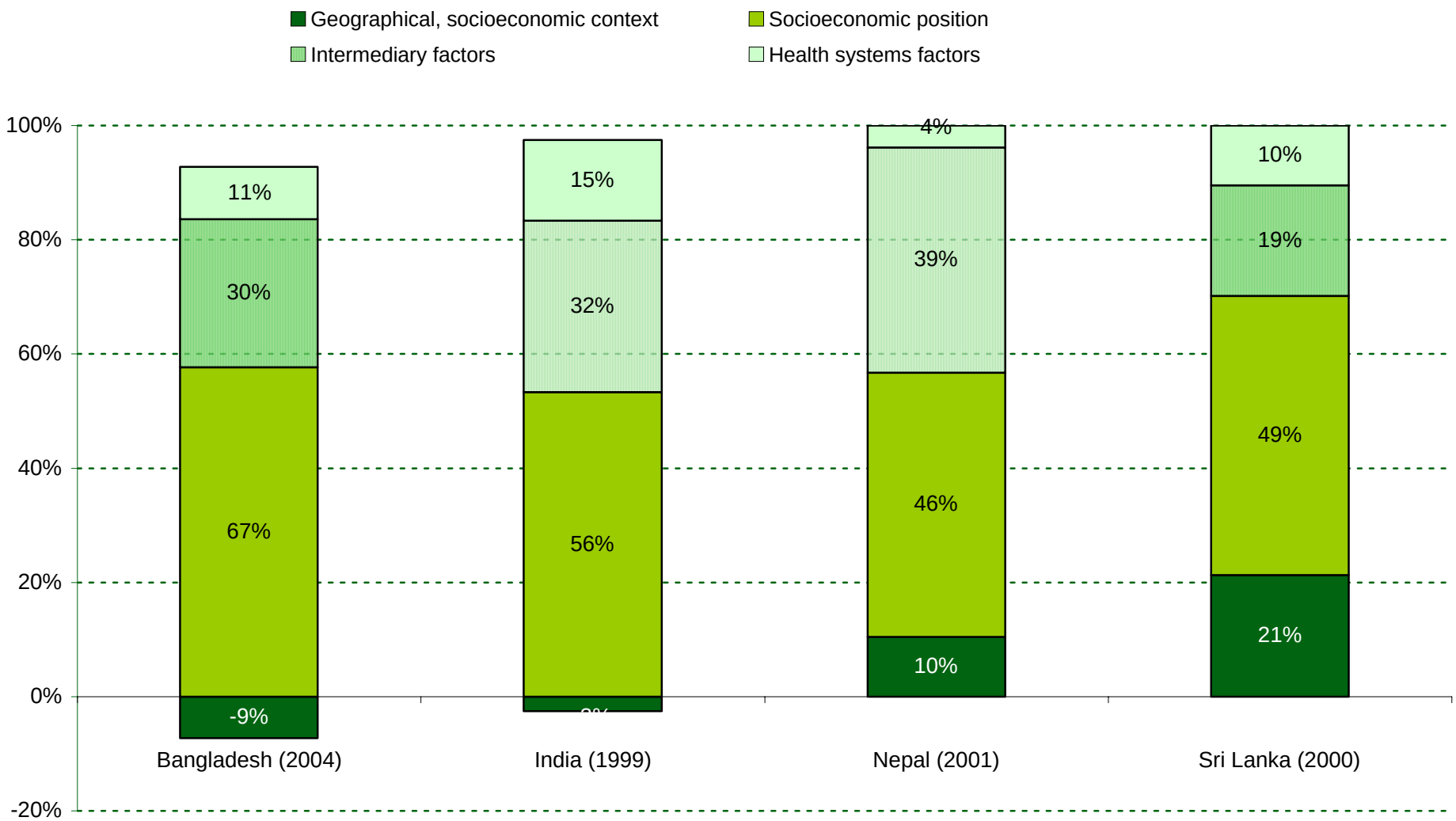
Inequalities in *stunting prevalence* between the poorest and richest wealth quintiles by country



Factors Contributing to Inequities in Skilled Birth Attendance



Factors Contributing to Inequities in Stunting



Conclusions

- Health disparities are seen among various social determinants
- Disparities by income level are larger than disparities by urban/rural residence and educational level
- Expanding coverage to the population tends to reduce inequality
- Stunting influenced less by health system factors than skilled birth attendance
- Income is not reason for inequalities. Other factors include those that affect access to health system, health behaviour, etc.