Applying an Equity Lens to Health Care Issues of Women in Pakistan

Naushin Mahmood
PIDE, Islamabad

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Introduction and Background

- Population health status closely linked with quality and equitable distribution of health care services
- Equitable health---a means to attain human development, poverty reduction, and ‘Health for All’ goals
- Large variations in health status indicators are evident around the world with wide gap between rich and poor countries and even within countries
- Uneven health equity patterns gaining a renewed attention in this Millennium to improve health conditions of the poor and the marginalized population

What is Health Equity?

- Concept of health equity and its measurement remains an ambiguous and complex issue if interpreted in terms of fairness and social justice

- Generally, it may be defined as,“ inequalities in health status, risk factors, or health service utilization between individuals or groups, that are un-necessary, avoidable, and unfair” (WHO,1998)

- Hence, socioeconomic status reflecting wide health gaps are not simply inequalities, they are also inequities—increasingly recognized by international community as inequalities that are unfair and unjust

- The assessment of health equity, therefore, requires comparisons between more and less advantaged social groups for health and development programs & policies

Health Profile of Pakistan

- Pakistan's population continues to carry a heavy burden of disease and poor health care practices with low health status indicators when put in a comparative perspective in the region

- Performance of health services in public sector indicates large gap between set targets/promises and reality with low quality of service provision

- Huge expansion of private health sector facilities in the last two decades largely functioning in unregulated manner and catering to the needs of the non-poor.

- Public health expenditure is not just abysmally low, it has not changed much the last three decades

Table 1: Trends in Women Health Related Indicators in Pakistan: 1991-2007

Indicator	1990-91 (PDHS)	1996-97 (PFFPS)	2000-01 (PFPRHS)	2006-07 (PDHS)
Total fertility rate	5.4	5.4	4.8	4.1
Median age at first birth	21.3	21.3	-	22
Contraceptive use	11.8	23.9	27.6	29
Modern method	9.0	16.9	20.2	22
Unmet need	38.0	37.5	33	25
Infant mortality rate	94.0	92.0	-	78
Under-five mortality	120.0	111	-	94
Prenatal care	25.6	31.6	43.3	61
Births by skilled person	18.8	-	-	39
Birth in a health facility	13.4	17.2	22.9	34

Why Study Health Care Inequities?

- Women health care is an important predictor of health status outcomes making it important to assess the change

- The maternal health indicates low status in terms of frequent closely spaced pregnancies, reproductive health related morbidity, high maternal mortality, unsafe abortions, nutritional deficiencies, and poor health care practices, justifying to better understand inequity in access to health care services
- Monitor progress toward MDG 5 (improving maternal health)

- Health Policy 2001 has a priority shift from curative to preventive, and from urban to rural sector with more focus on mother and child health

The Present Study---

- Examines how equitable the access and utilization of health care services are among poor and non-poor women and how do patterns vary across socioeconomic subgroups?
- Has use of services improved or deteriorated overtime in accessing public or private health facilities?
- Whether the trend in accessing services reflects widening or improving inequality in health care indicators?
- Applying an equity lens to use of health care services assumes that each individual has access to a minimum standard of services and has the same **opportunity to access** or utilize services if and when needed, irrespective of their economic, social, and demographic characteristics

Data Used and Methods

- Two datasets are used:
- The Pakistan Demographic and Health survey (PDHS) 2006-07, the largest-ever household based sample of more than 10,000 ever-married women aged 15-49 years, and this study confined to 5700 women who had a live birth in the 5 years preceding the survey with detailed information on their background characteristics and various health-care related indicators----------
- The 1990-91 PDHS dataset based on a sample of more than 6000 ever-married women, and this study confined to 4005 women selected parallel to the other dataset

- The rationale behind choosing these datasets (detailed information on ‘wealth status’ and women health care and background indicators, conducted by same organization, similar methodology, scope and structure, assess change)

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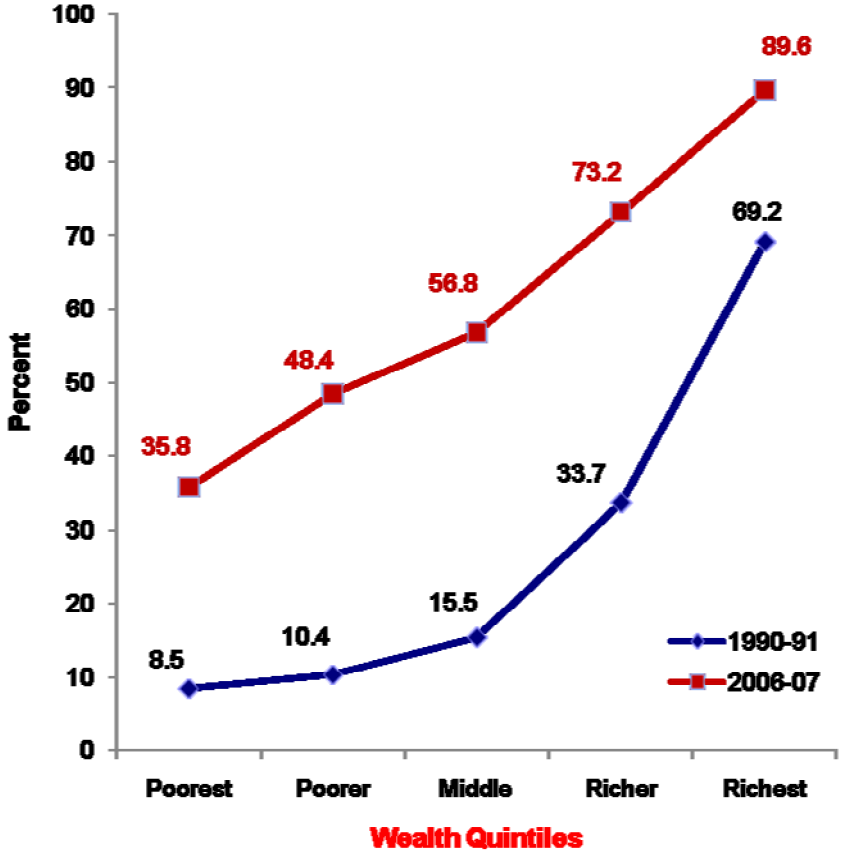
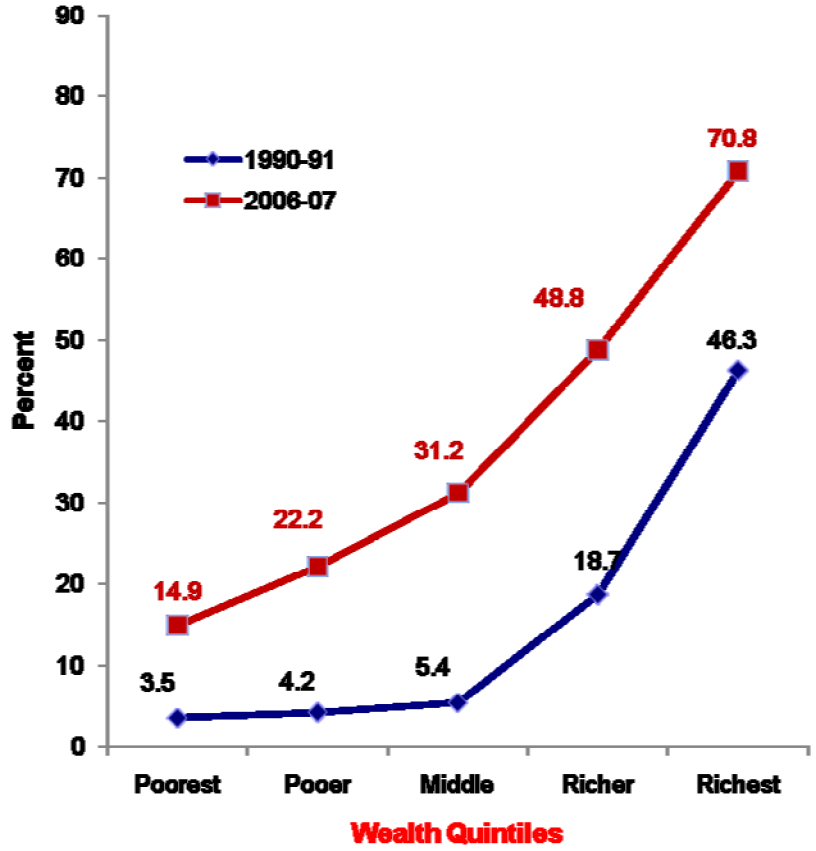
- Two health indicators, 'Prenatal Care' and 'Delivery Care' are used to study variations across subgroups

- Simple measures are used in the analysis including the wealth quintiles, percentages, relative ratios, and absolute difference between the highest and lowest socioeconomic groups to identify patterns of inequity and measure change overtime. The methods used are well-established and widely used in a number of countries generating DHS datasets
- To see whether wealth status has a stronger impact on use of services than education or residence, logistic and multinomial regressions are run for 2006-07 dataset controlling for age, residence and education

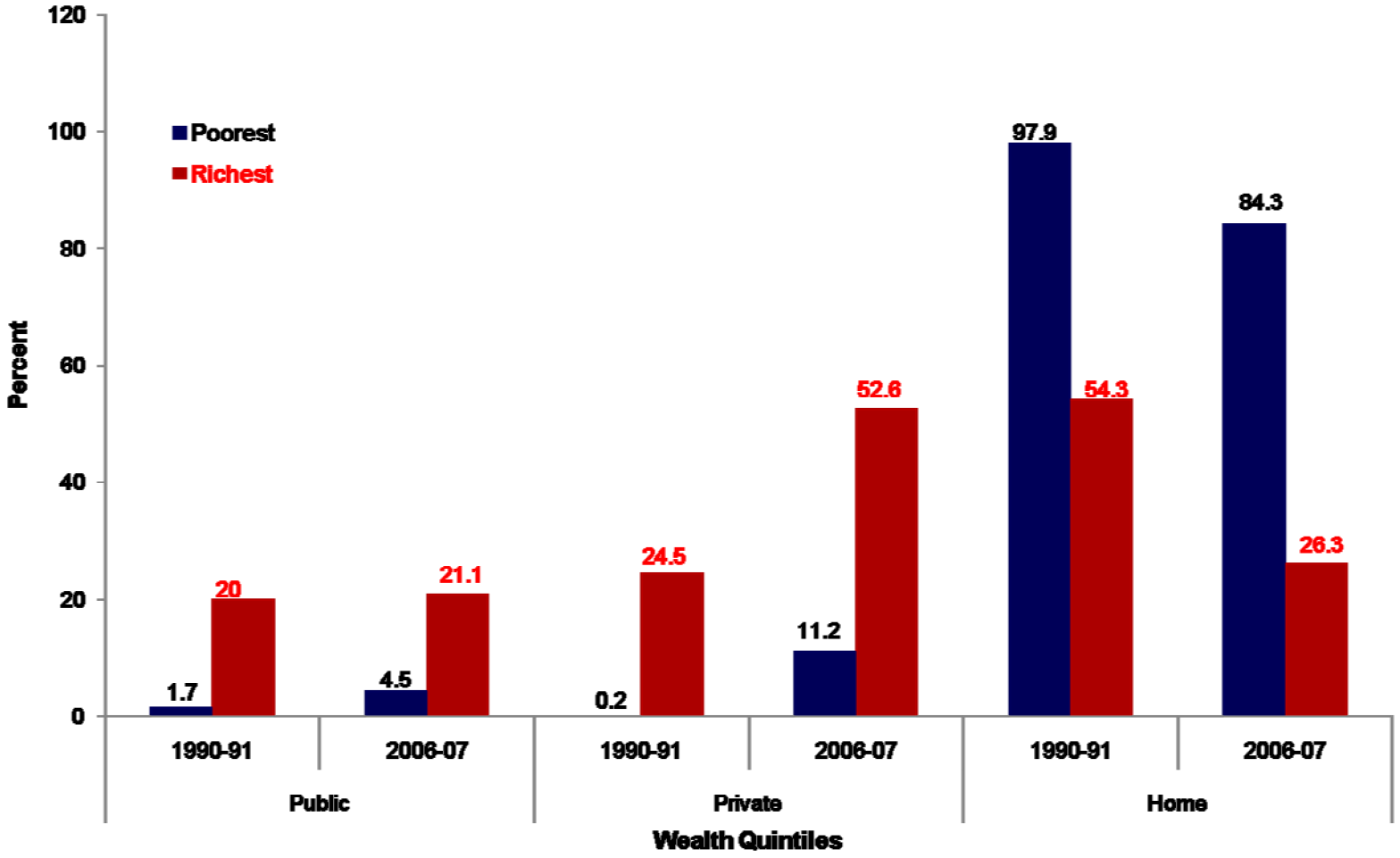
RESULTS

Inequity pattern in Accessing Skilled Health Personnel by wealth Status: 1991-2007



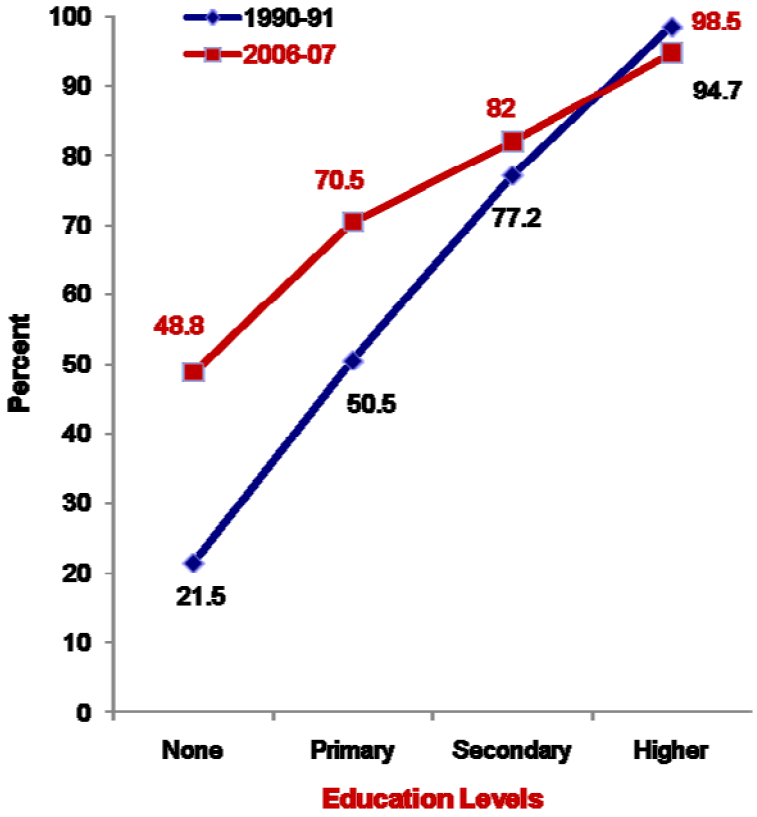


Inequity Pattern in Accessing Public and Private Health facilities by Wealth Quintiles:1991 & 2007

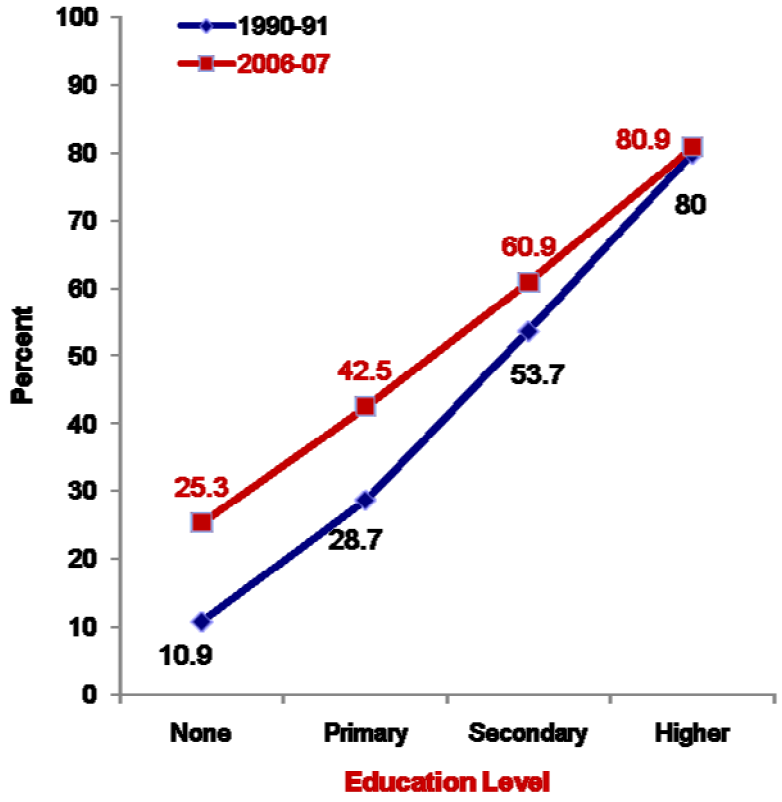


Inequity patterns in Accessing Skilled Health Person by Women Education Levels:1990-2007

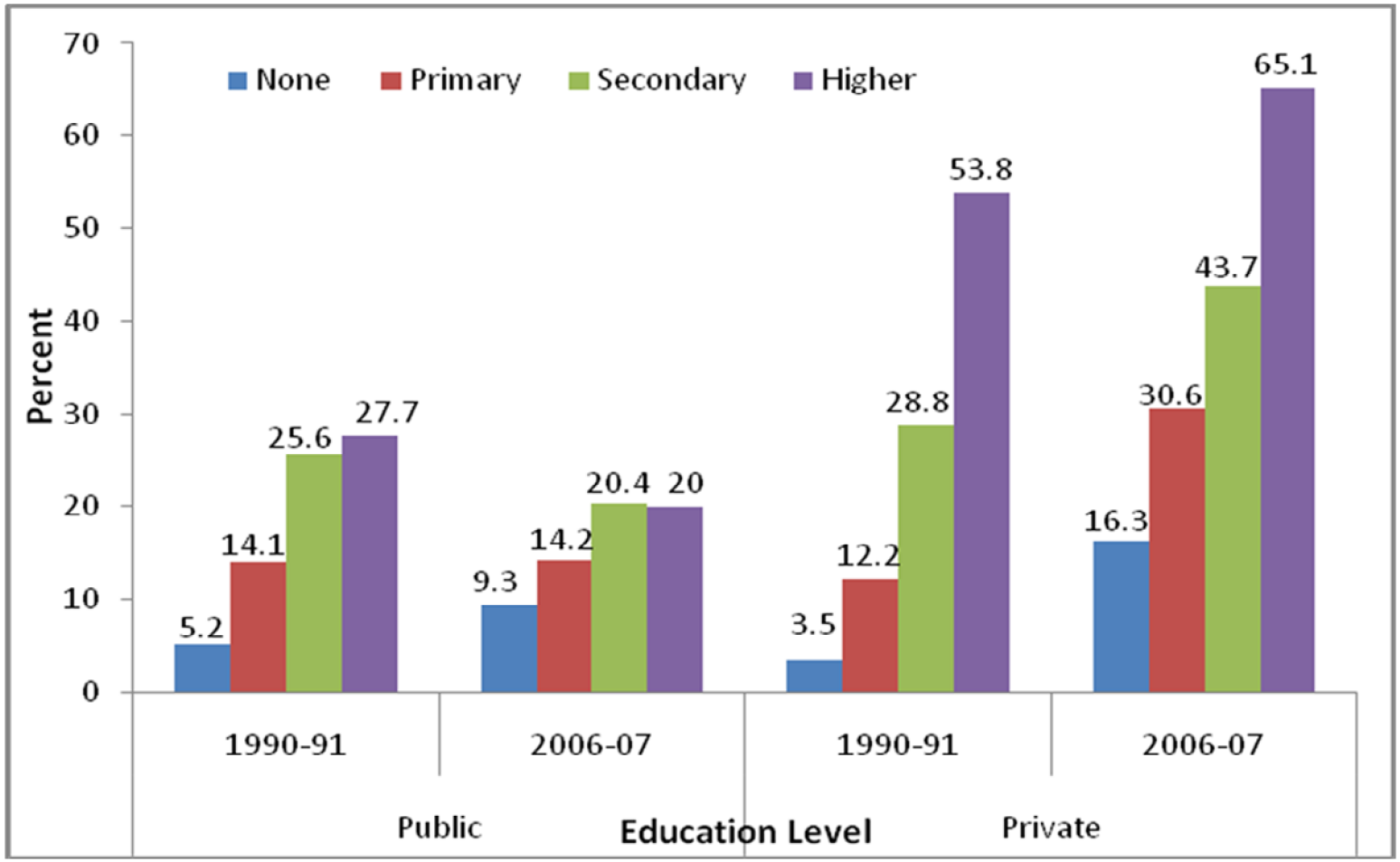
Prenatal Care



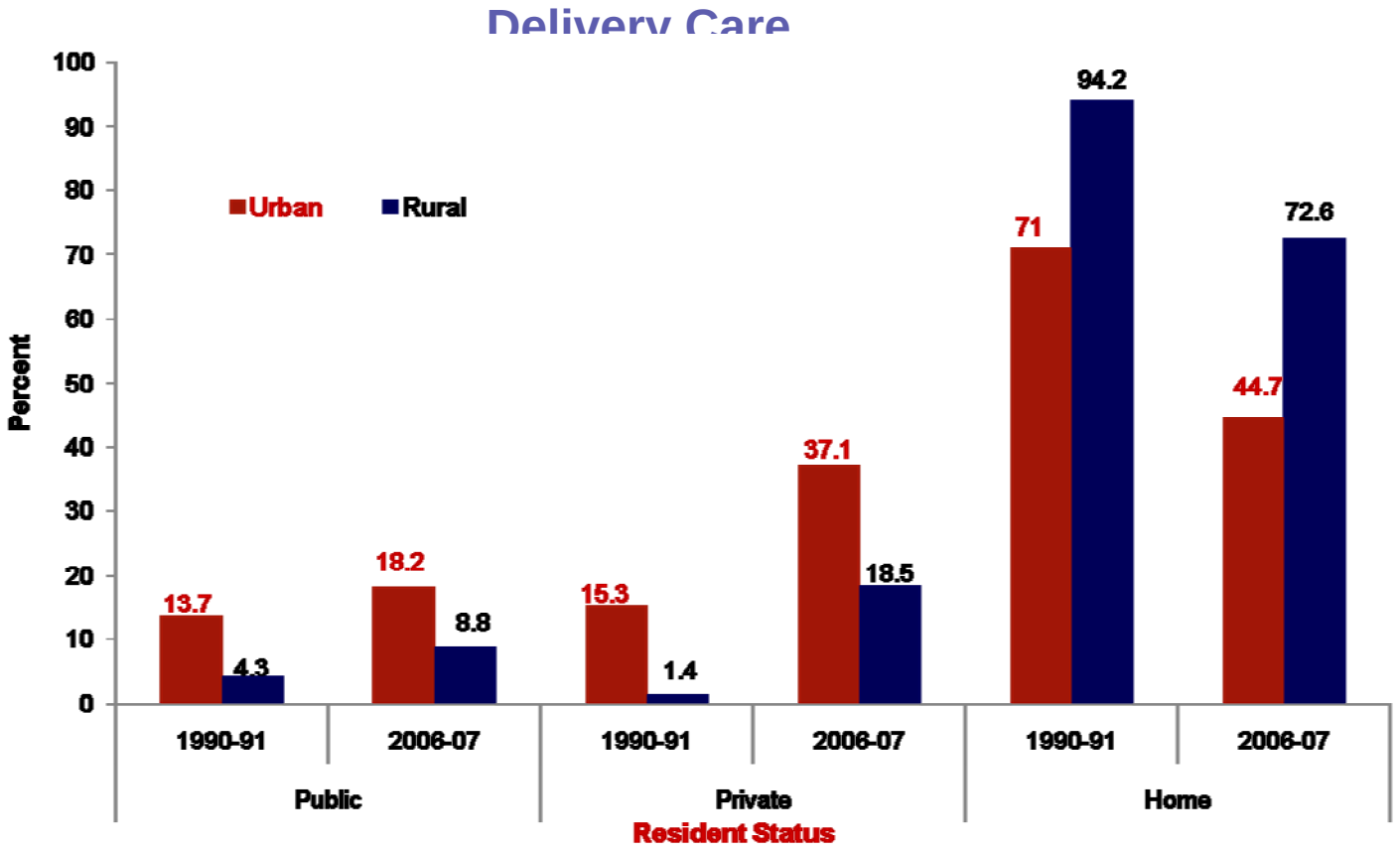
Delivery Care



Inequity pattern in Accessing Public and Private facilities for Delivery Care by Education: 1991-2007



Inequity Pattern in Accessing Public & Private Health facilities for Delivery Care by Education Levels:



Regression results: 2006-07

	Facility based Delivery Care		Pre-Natal Care
Variables	Public	Private	Skilled
Wealth Status			
Poorest	.142	.175	.133
Poorer	.248	.247	.209
Middle	.381	.287	.272
Richer	.611	.490	.501
Richest	-	-	-
Women's Education			
None	.287	.152	.192
Primary	.365	.247	.314
Secondary	.557	.368	.383
Higher	-	-	-
Place of Residence			
Urban	1.498	1.301	1.251
Rural	-	-	-
Age Group			
15-24	1.120	.919	.723
25-34	1.199	1.239	1.106
35+	-	-	-
(N)	(691)	(1427)	(3370)

Conclusions and Discussion

- An overall improvement in inequity patterns of health care among married women during the period under study beginning in urban areas and more recently spreading to rural areas

- The change witnessed over the last decade is not large enough to bridge the health gap between the rich and the poor where inequities are large

- The dominance of wealth differentials suggests that costs of using services are significant in keeping use of health care services low, especially when observed for private health services among the poor

- The inequity pattern disfavoring the poor and majority of uneducated women is likely to jeopardize achievement of 4 & 5 0f MDGs and other national and regional health care targets
- The results reinforce the earlier evidence-----
- Some limitations of the study

Thank You!