Chapter 2

Health inequalities

Unequal access to fundamental rights and services – such as health care – required for individuals to sustain and improve their livelihoods stifle economic growth and poverty reduction and undermine social cohesion and stability (UNESCAP, 2017).

The United Nations 2030 Agenda for Sustainable Development aims to leave no one behind, and the reduction of inequalities is said explicitly in SDG 10 "to reduce inequality within and among countries". SDG 3 is a call to ensure healthy lives and promote well-being for all at all ages, which implies tackling inequalities in health (WHO, 2017a).

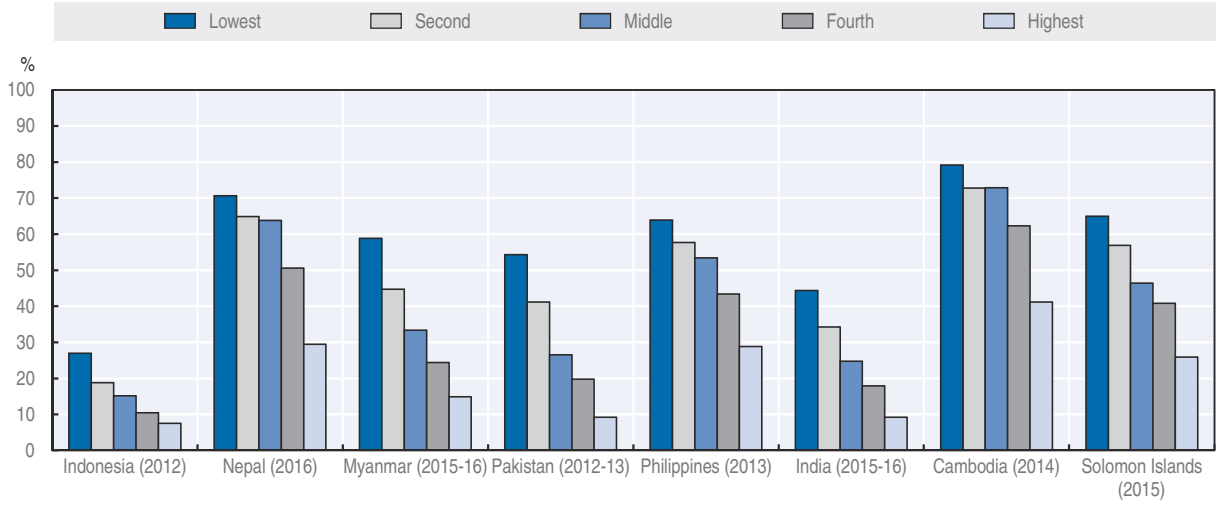
The aim of this chapter is to explore health inequalities across a number of social determinants: gender, economic status, education and place of residence. Evidence suggests that certain socially disadvantaged groups tend to use health services less, although these groups may need health services more. This phenomenon, sometimes referred to as "inverse care law", can partly be explained by the fact that disadvantaged groups typically face multiple barriers in accessing services, such as financial, geographical and cultural barriers.

Using country data from Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), this chapter analyses disparities in access to care and use of services by also looking at changes over time. Comparing results from earlier and later surveys reveals that access rates to care for the most marginalised groups have improved. However, it also finds that women in worst-off households living in rural areas constantly report significant problems in accessing care when needed due to distance and financial reasons.

Disparities in access to care

A significant proportion of women aged 15-49 reported problems in access to health care when they are sick. Gender often interacts with other social factors such as income or residence, which may lead to compound disadvantage. In Cambodia, Nepal, the Philippines and the Solomon Islands, more than three women in four with the lowest household income reported difficulties in accessing health care due to financial reasons (Figure 2.1). In Cambodia, over 40% of women from households with the highest income also have problems with access to care due to financial reasons, while in India, Indonesia and Pakistan, less than one woman in ten from household in the richest quintile have unmet care needs due to financial reasons.

Figure 2.1. **Women aged 15-49 who reported problems in accessing care due to financial reasons, by income quintile**



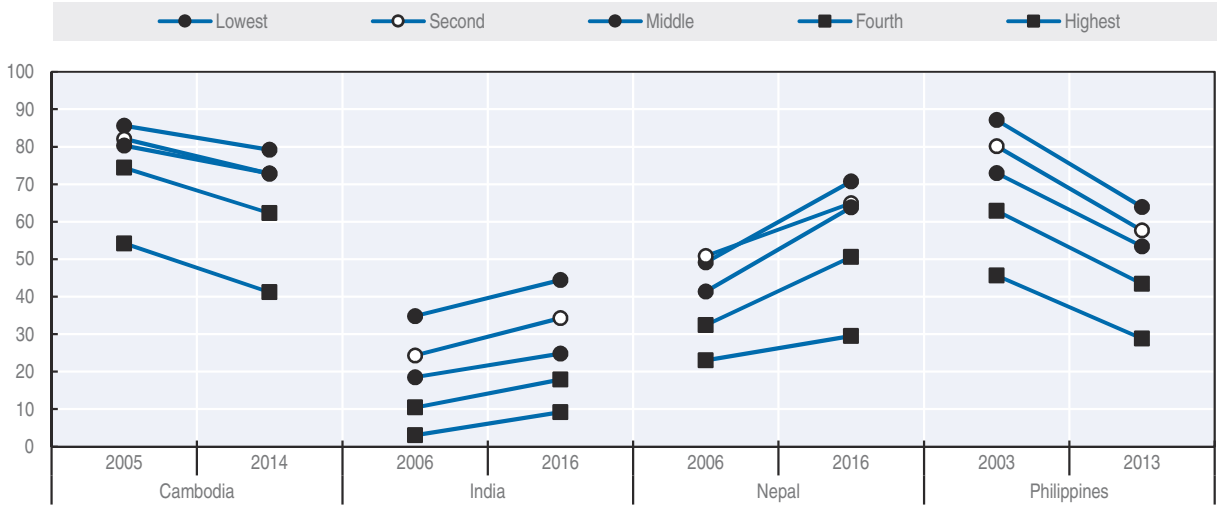
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866619

Over time, the proportion of women who reported problems in access to health care due to financial reasons decreased in Cambodia and the Philippines for all income groups, whereas it increased in India and Nepal for all income groups. The distance between groups with the lowest income and the highest income increased in Cambodia, India and Nepal. The Philippines saw significant increases both in terms of access and in closing the gap with the worst-off groups (Figure 2.2).

However, inequalities go beyond income. In Cambodia, Nepal and the Philippines, almost three women in four with no education have problems in accessing care due to financial reasons. In Pakistan, the proportion of women with no education reporting problems in accessing care due to financial reasons is more than three times the proportion of women with secondary or higher education (Figure 2.3).

Figure 2.2. **Change in the proportion of women aged 15-49 who reported problems in accessing care due to financial reasons, by income quintile**



Source: DHS and MICS surveys, various years.

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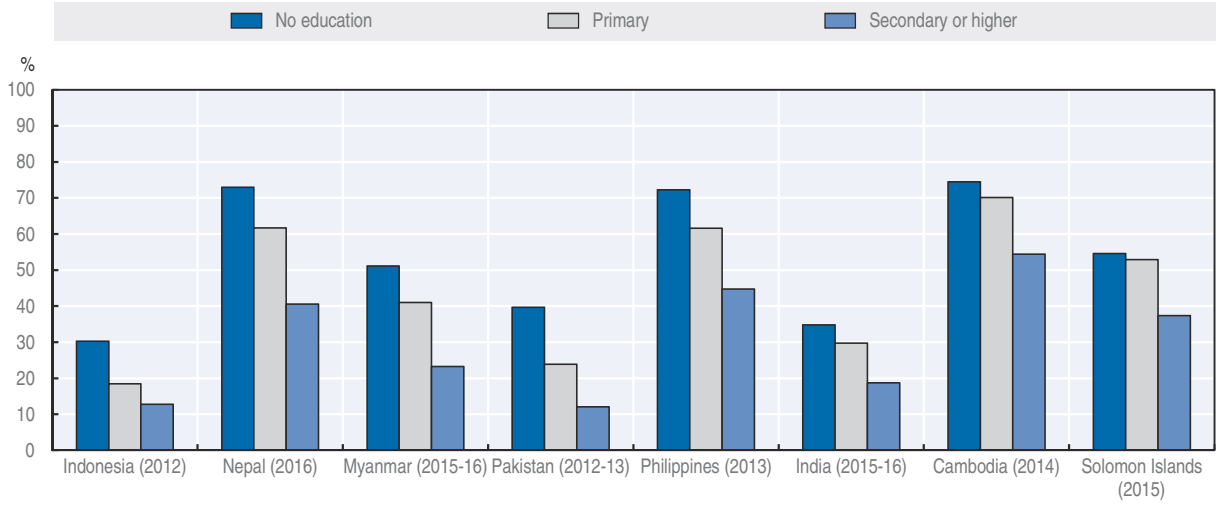
Figure 2.3. **Women aged 15-49 who reported problems in accessing care due to financial reasons, by education level**



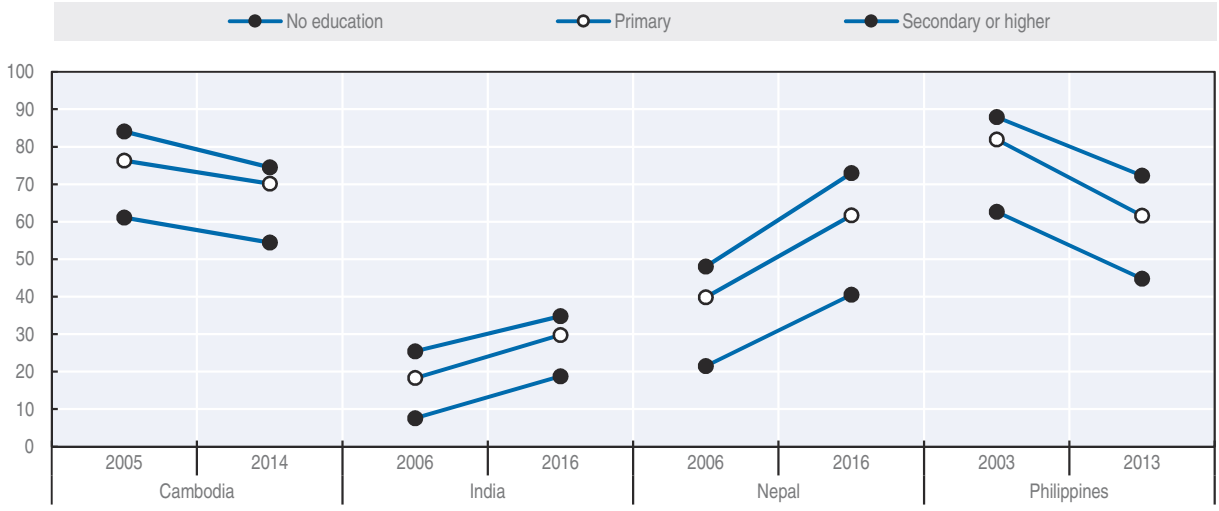
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866942

Nepal reported a significant decrease in terms of access to care for women in all education groups, and the gap in problems accessing care due to financial reasons between women with no education and women with secondary or higher education increased (Figure 2.4). On the contrary, Cambodia saw an increase both in terms of access and in closing the gap with the less educated groups.

The urban-rural divide in access to care due to financial reasons is less pronounced than the ones due to income and education levels. However, in Pakistan and the Solomon Islands the proportion of women living in rural areas reporting financial problems in accessing care is twice the proportion of women living in urban areas (Figure 2.5).

Figure 2.4. **Change in the proportion of women aged 15-49 who reported problems in accessing care due to financial reasons, by education level**



Source: DHS and MICS surveys, various years.

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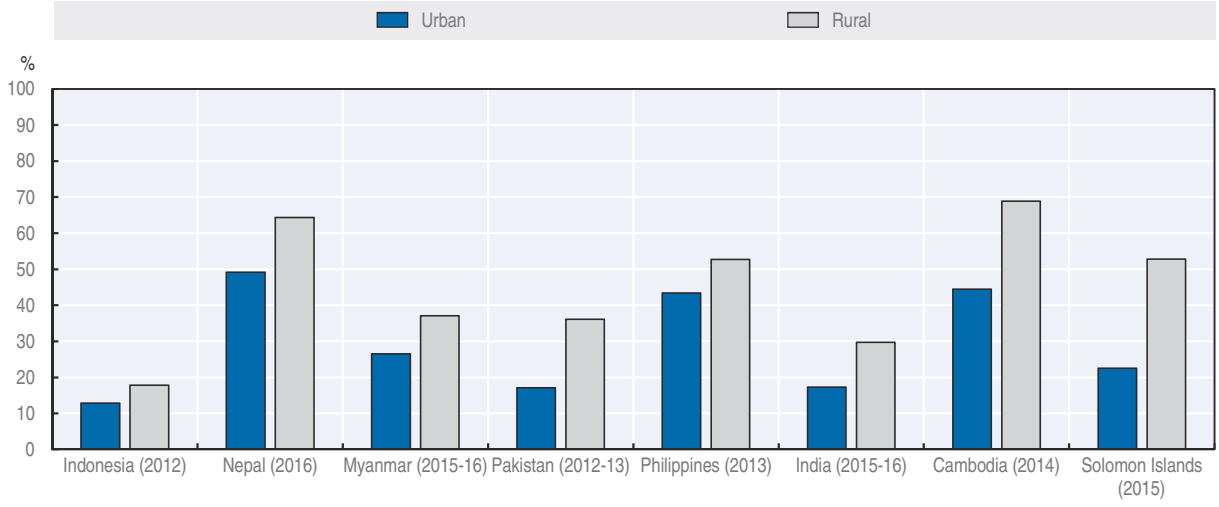
Figure 2.5. **Women aged 15-49 who reported problems in accessing care due to financial reasons, by geographical location**



Source: DHS and MICS surveys, various years.

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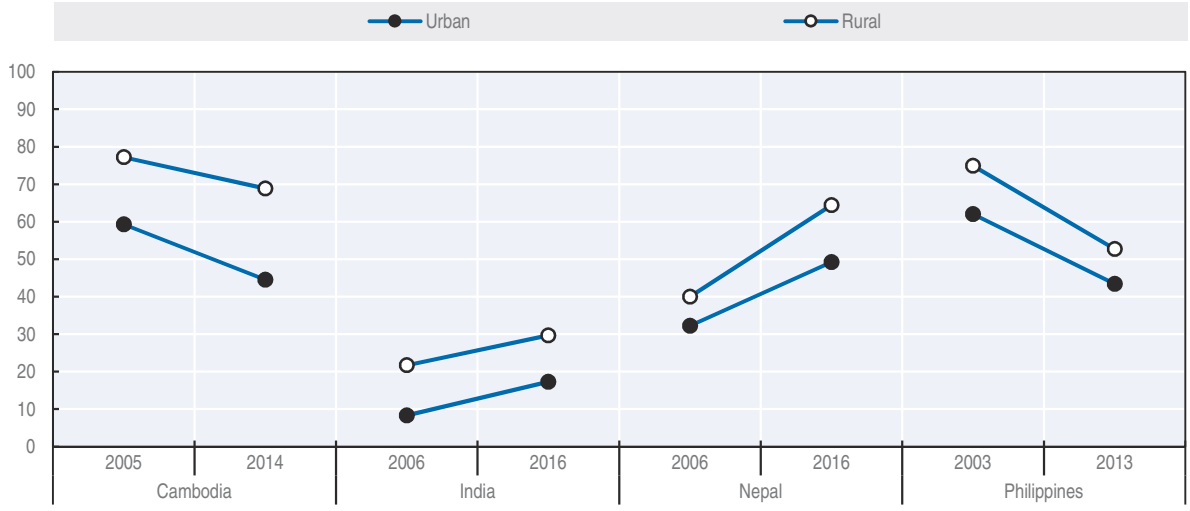
Cambodia and the Philippines reported better access to health care for women living in urban and rural areas over time. However, the rural-urban divide widened in Cambodia, while it narrowed down in the Philippines (Figure 2.6).

Distance to providers represents another barrier in access to health care that intersects with income. Many women in the lowest household income quintile have serious problems with health care access due to distance. In Nepal, Pakistan and the Solomon Islands, about two women in three from worst-off households reported having unmet care needs due to distance, whereas in Indonesia only one woman in five among worst-off households reported problems in accessing care due to distance (Figure 2.7).

Figure 2.6. **Change in the proportion of women aged 15-49 who reported problems in accessing care due to financial reasons, by geographical location**



Source: DHS and MICS surveys, various years.

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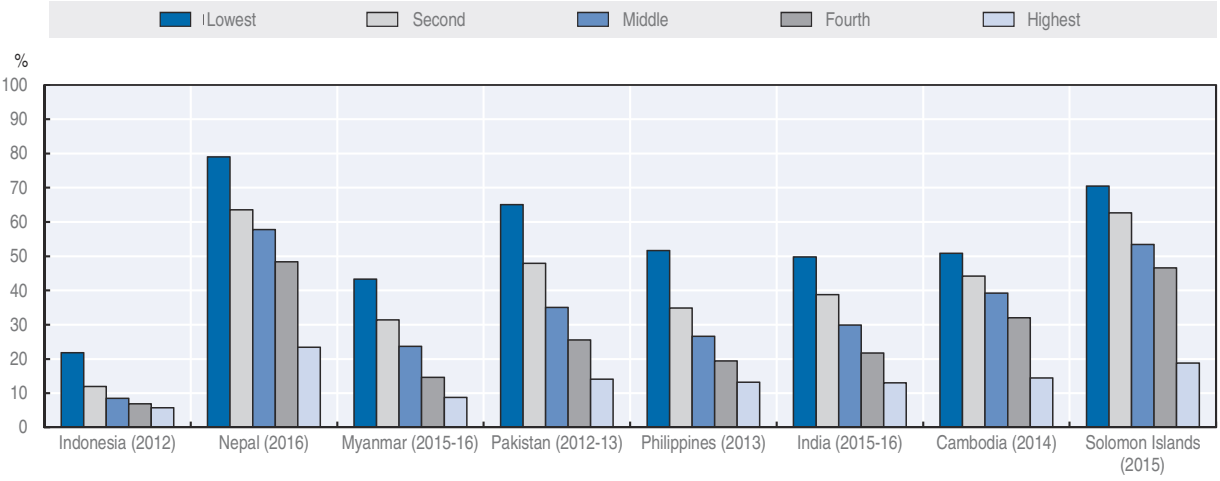
Figure 2.7. **Women aged 15-49 who reported problems in accessing care due to distance, by income quintile**



Source: DHS and MICS surveys, various years.

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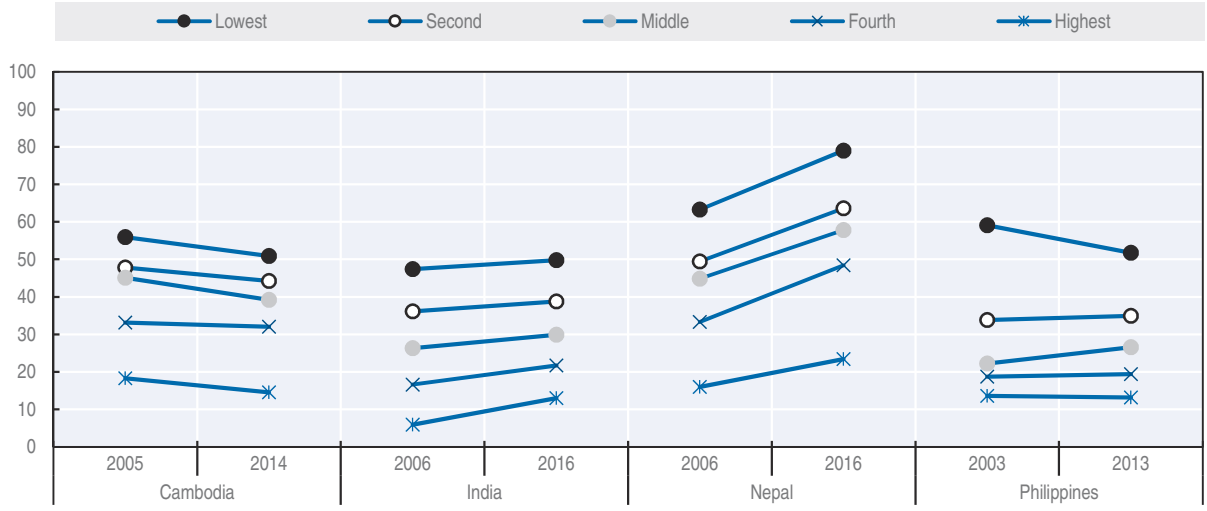
Among better-off households, 23.4% of women reported problems in access due to distance in Nepal. The gap in access to care due to distance between women living in worst-off households and women living in better-off household is large and similar across reporting countries, and a woman in the lowest income quintile experiences problems in access to care due to distance between three and five times more than a woman in the highest income quintile.

Over time, the problems in access to care due to distance increased in India and Nepal for women in all income groups, while the situation improved in Cambodia (Figure 2.8). The gap in problems in access to care between the better-off and the worst-off women narrowed down in Cambodia, India and the Philippines, whereas it widened in Nepal.

Figure 2.8. **Change in the proportion of women aged 15-49 who reported problems in accessing care due to distance, by income quintile**



Source: DHS and MICS surveys, various years.

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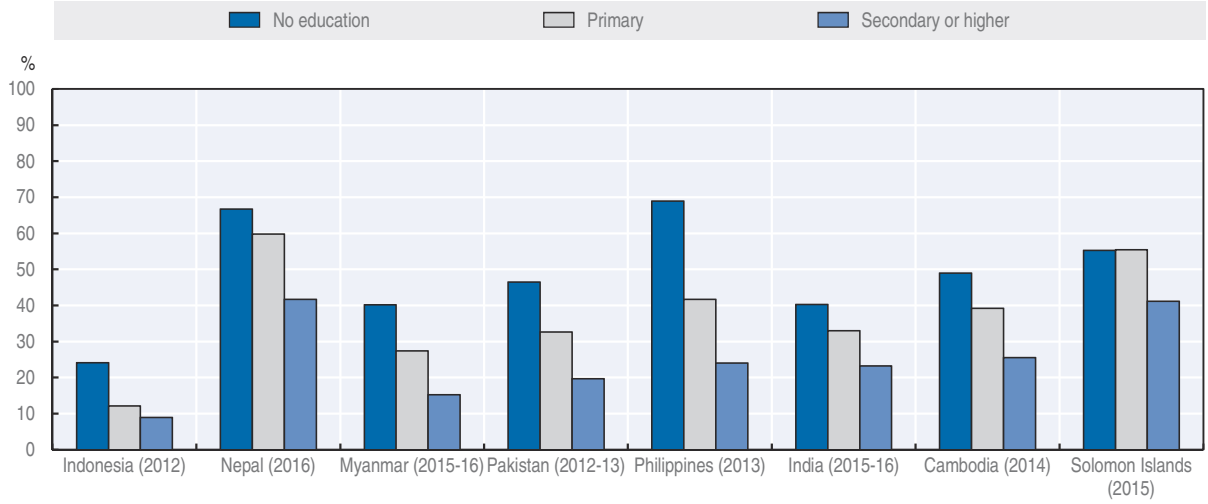
The gap in access due to distance is less pronounced by education level than by income level (Figure 2.9). However, in the Philippines a woman with no education has three times more problems in accessing care due to distance than a woman with secondary or higher education.

Figure 2.9. **Women aged 15-49 who reported problems in accessing care due to distance, by education level**

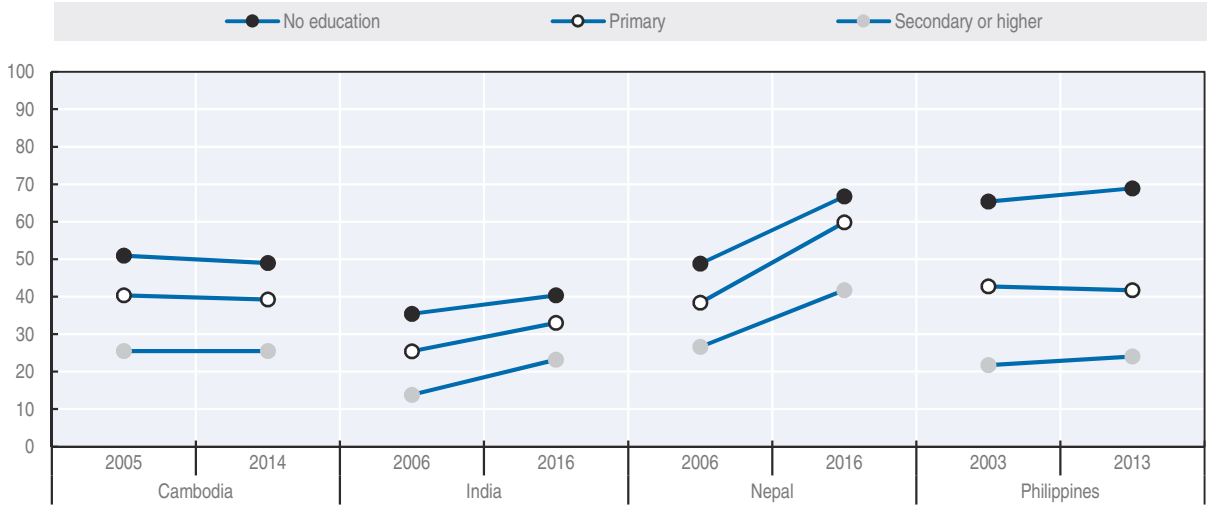


Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933867056

Over time, access to care slightly improved in Cambodia for all education groups (Figure 2.10). In India, the gap in problems in accessing care due to distance between women with no education and women with secondary or higher education narrowed down, even if more women in both groups reported increased problems in access, whereas

Figure 2.10. **Change in the proportion of women aged 15-49 who reported problems in accessing care due to distance, by education level**



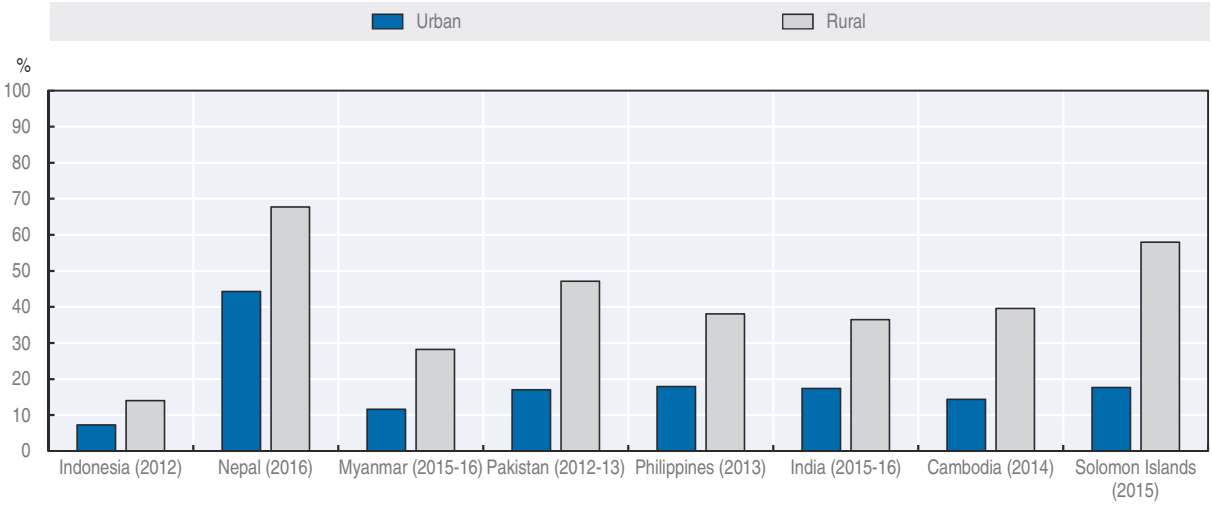
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866638

in Nepal problems in access to care increased in all education groups and the gap between women with no education and high-educated women increased too.

The proportion of women with unmet care needs due to distance is consistently larger in rural areas than urban areas, suggesting that the offer of health care services may be less adequate in rural areas (Figure 2.11). In Nepal, more than two women in three living in rural areas reported problems in access to care due to distance. In the Solomon Islands, a woman living in rural areas reported more than three times problems in access to care due to distance as compared to a woman living in urban areas.

Figure 2.11. **Women aged 15-49 who reported problems in accessing care due to distance, by geographical location**

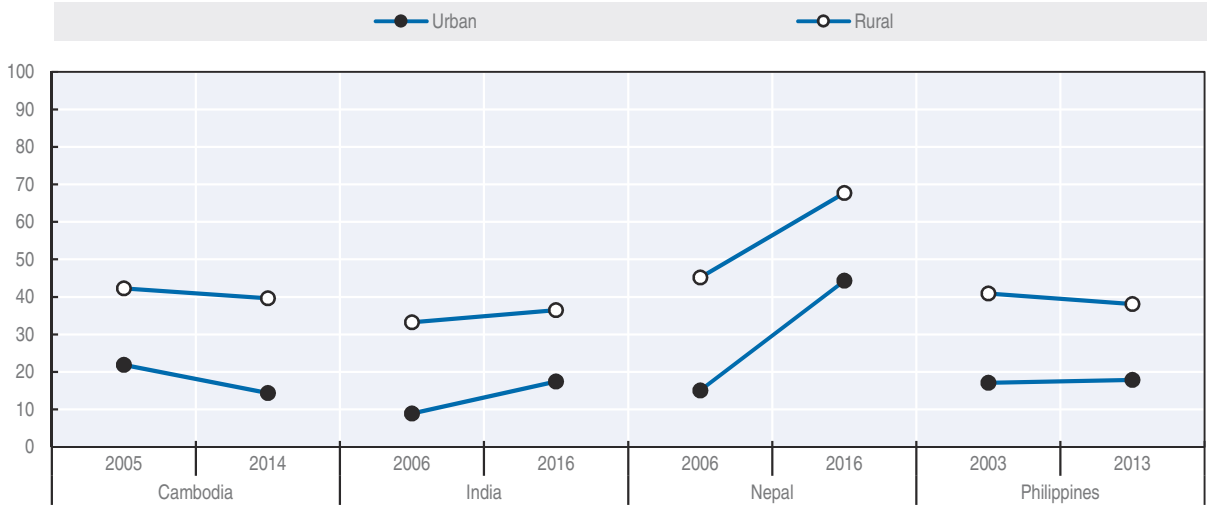


Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866657

The rural-urban divide in access to care due to distance decreased in India, Nepal and the Philippines, even if the proportion of women reporting problems in access to care due to distance increased for both geographical location groups in both India and Nepal (Figure 2.12).

Figure 2.12. **Change in the proportion of women aged 15-49 who reported problems in accessing care due to distance, by geographical location**



Source: DHS and MICS surveys, various years.

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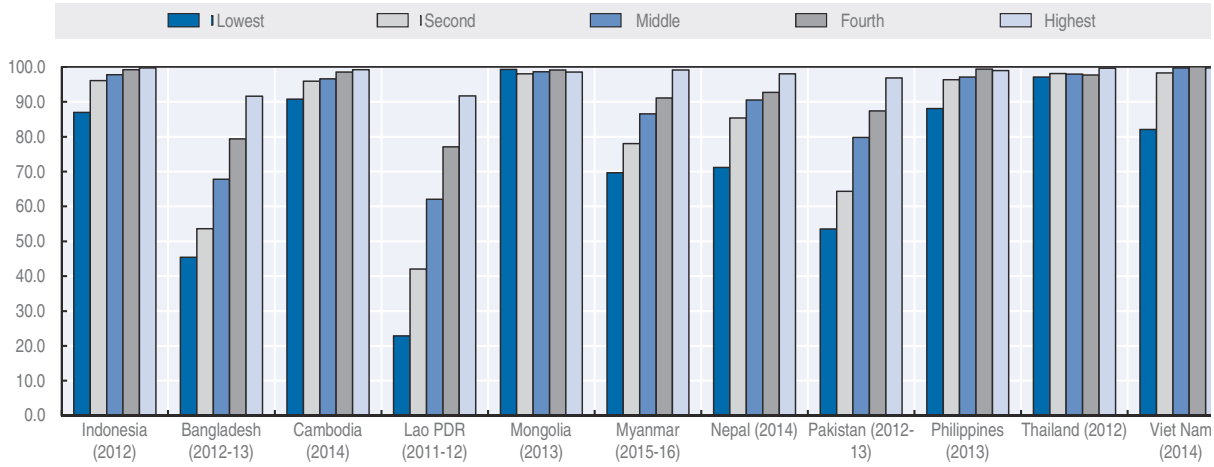
Disparities in use of services

This analysis looks at three indicators to also review progress over time in the use of health services: access to antenatal care; access to treatment for children with diarrhoea; and DPT3 immunisation coverage. While the indicators described below do not provide an exhaustive list, they are an illustration of disparities in the use of essential services in Asia-Pacific. Beyond disparities based on income, it should be noted that there are many other forms of social exclusion – such as gender, race, ethnicity, age, employment status, sexual orientation and health status – that often interact with poverty and education, acting as strong determinants of inequalities in health and access to care for disadvantaged groups.

Access to antenatal care by skilled professionals varies by income quintile across reporting Asia-Pacific countries (Figure 2.13). In Cambodia, Indonesia, Mongolia, the Philippines and Thailand, antenatal care coverage is high for all women aged 15-49 who had a recent live birth, whereas in Lao PDR one woman in four in the worst-off households reported access to antenatal care. In Lao PDR, the proportion of women who reported at least one antenatal care visit is four times higher for mothers in the richest households than for mothers in the poorest households.

All reporting countries showed an increase in the use of antenatal care for all income groups over time (Figure 2.14). However, the divide between the better-off and the worst-off women in access to antenatal care remains quite large in Bangladesh, Lao PDR and Pakistan. This illustrates the importance of sustaining action to equity-focused approaches to health as countries advance the SDGs in Asia-Pacific.

Figure 2.13. **Women aged 15-49 who reported at least one antenatal visit, by income quintile**



Source: DHS and MICS surveys, various years.

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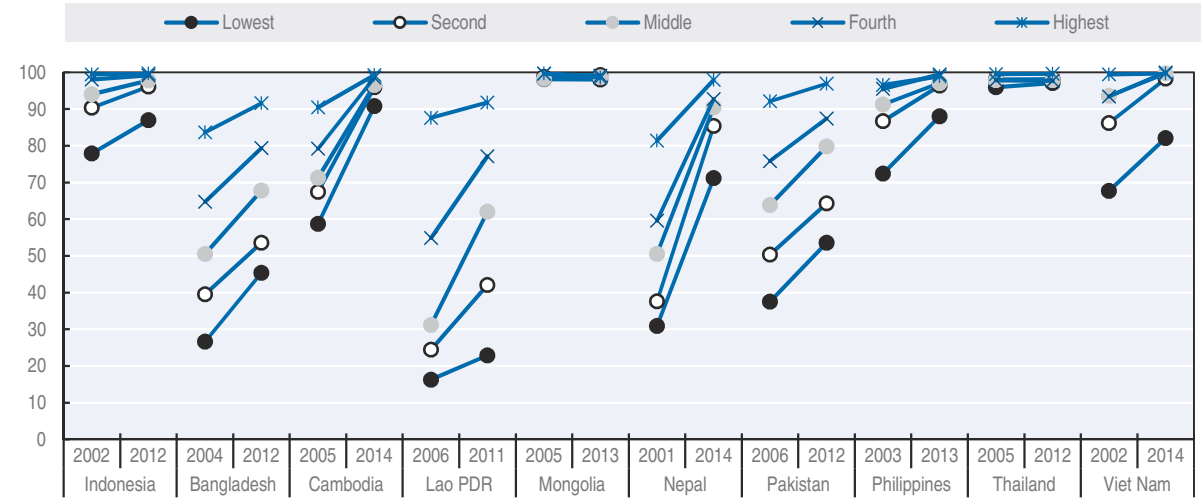
Figure 2.14. **Change in the proportion of women aged 15-49 who reported at least one antenatal visit, by income quintile**



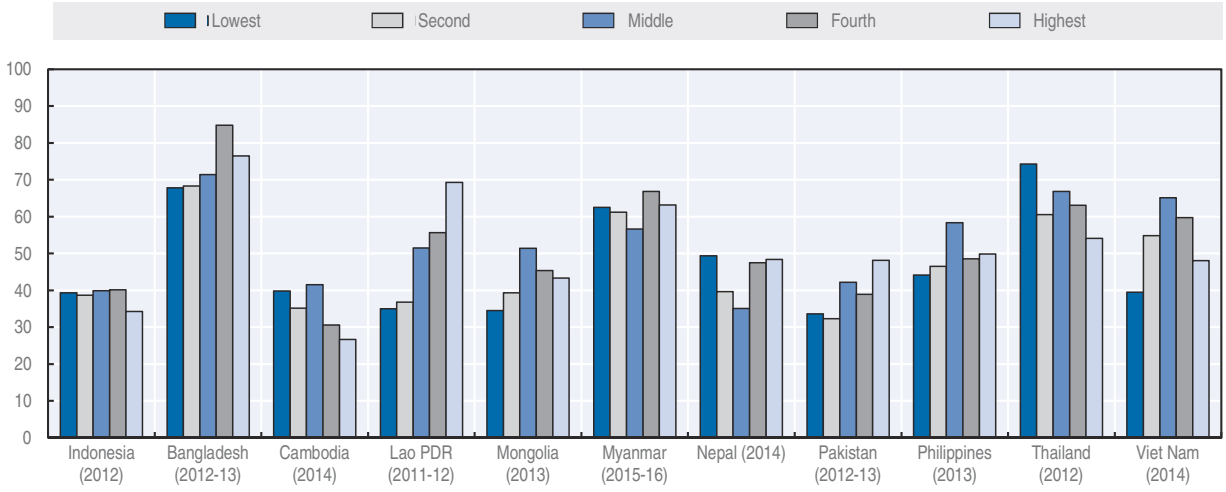
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866714

In Bangladesh, Myanmar and Thailand more than one child in two with diarrhoea receives oral rehydration salts across all income groups, and disparities are small (Figure 2.15). However, in Lao PDR, children with diarrhoea from well-off households have two times higher access to treatment as compared to children in worst-off households.

All reporting countries showed an increase in the use of oral rehydration salts for children with diarrhoea across all household income groups over time, except in Pakistan for households in all quintiles but the highest (Figure 2.16). The divide between women in better-off households and women in worst-off households in access to oral rehydration for their children with diarrhoea remains quite small, suggesting that there are no disparities in the use of this health care service due to income.

Figure 2.15. **Children aged under 5 years with diarrhoea receiving oral rehydration salts, by household's income quintile**



Source: DHS and MICS surveys, various years.

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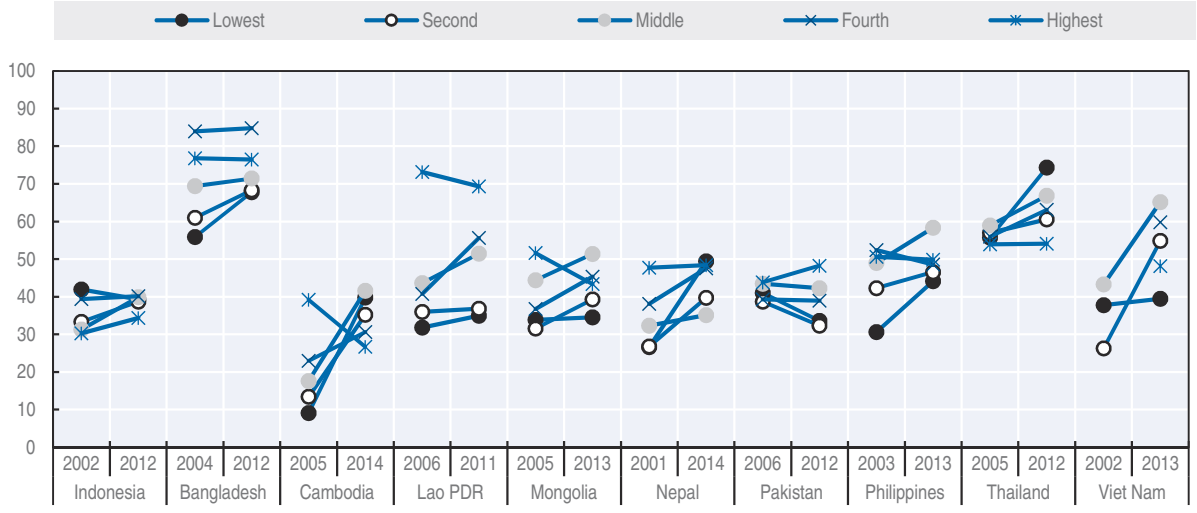
Figure 2.16. **Change in the proportion of children aged under 5 years with diarrhoea receiving oral rehydration salts, by household's income quintile**



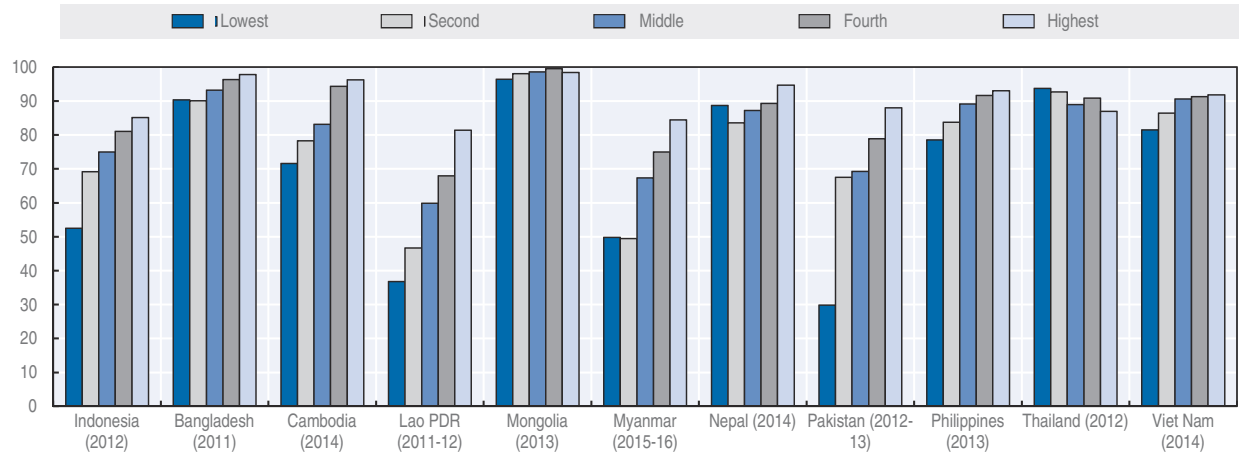
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866752

Universal coverage of children against vaccine-preventable diseases is crucial in reducing infant and child mortality (see indicator "Childhood vaccination programmes" in Chapter 5). Bangladesh, Mongolia, Nepal, Thailand and Viet Nam achieved high immunisation coverage among one-year old children for both poorer and richer households, but in countries such as Pakistan and Lao PDR inequalities are large with a difference of more than 50% in the proportion of children with DTP3 immunisation coverage living in well-off households compared to worst-off households (Figure 2.17).

All reporting countries showed an increase in DTP3 immunisation coverage among one-year old children for all household income groups over time, except in Thailand (all income

Figure 2.17. **DTP3 immunisation coverage among one-year old children, by household's income quintile**

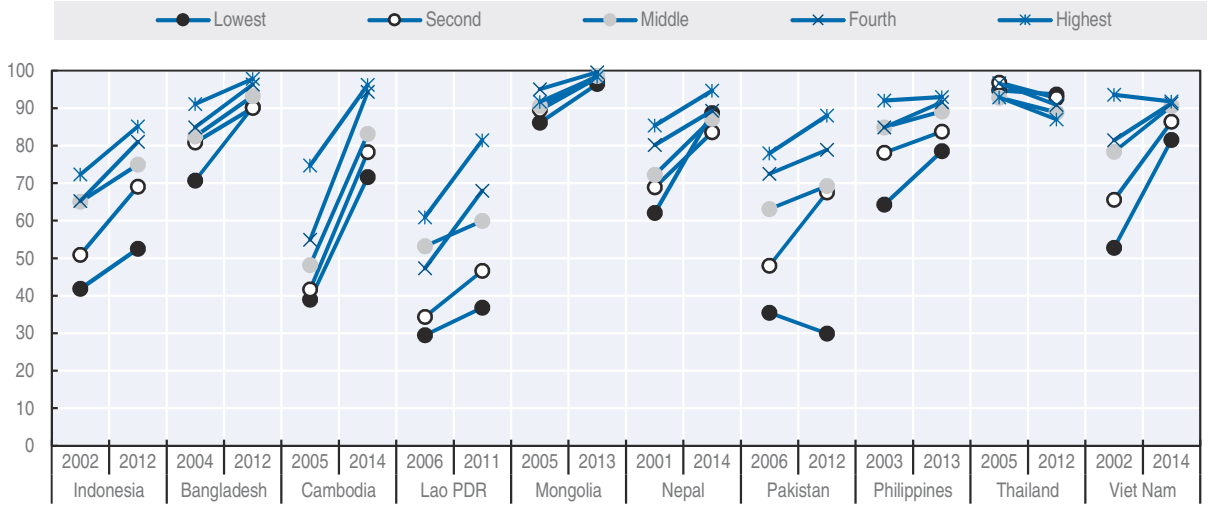


Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866771

groups) and in worst-off households in Pakistan (Figure 2.18). The divide in access to DTP3 immunisation coverage between children in worst-off households and children in better-off households was large and increasing over time in Indonesia, Lao PDR and Pakistan.

Figure 2.18. **Change in the proportion of DTP3 immunisation coverage among one-year old children, by household's income quintile**



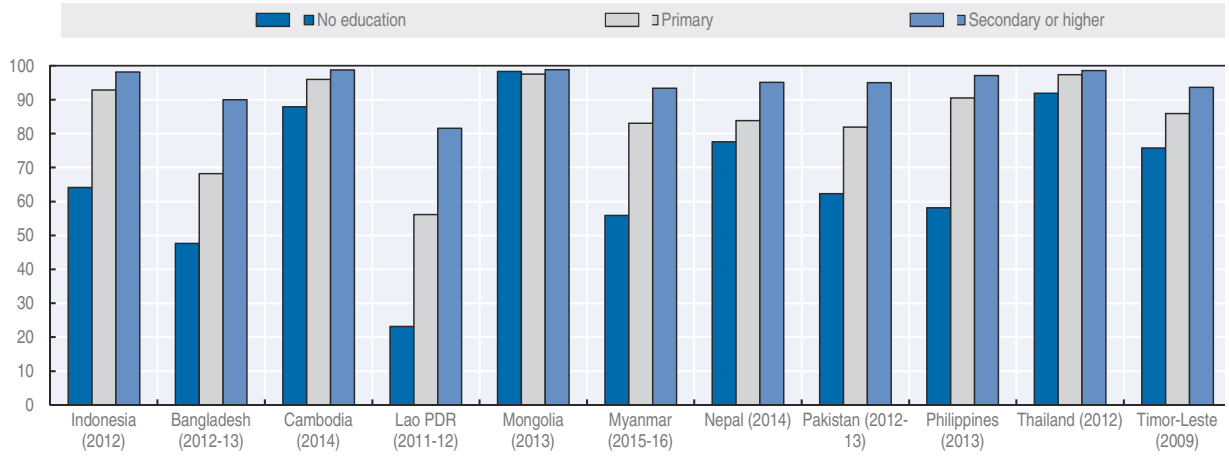
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866790

The gap in use of antenatal care by education groups is less pronounced than that by income levels (Figure 2.19). However, a large divide between women with no education and women with higher education in access to antenatal care is reported in Lao PDR.

All reporting countries showed an increase in the use of antenatal care for all education groups over time, except women with no education in Indonesia (Figure 2.20). The divide between women with no education and women with secondary or higher education in access to antenatal care remains quite large in Lao PDR.

Figure 2.19. **Women aged 15-49 who reported at least one antenatal visit, by education level**



Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866809

Figure 2.20. **Change in the proportion of women aged 15-49 who reported at least one antenatal visit, by education level**

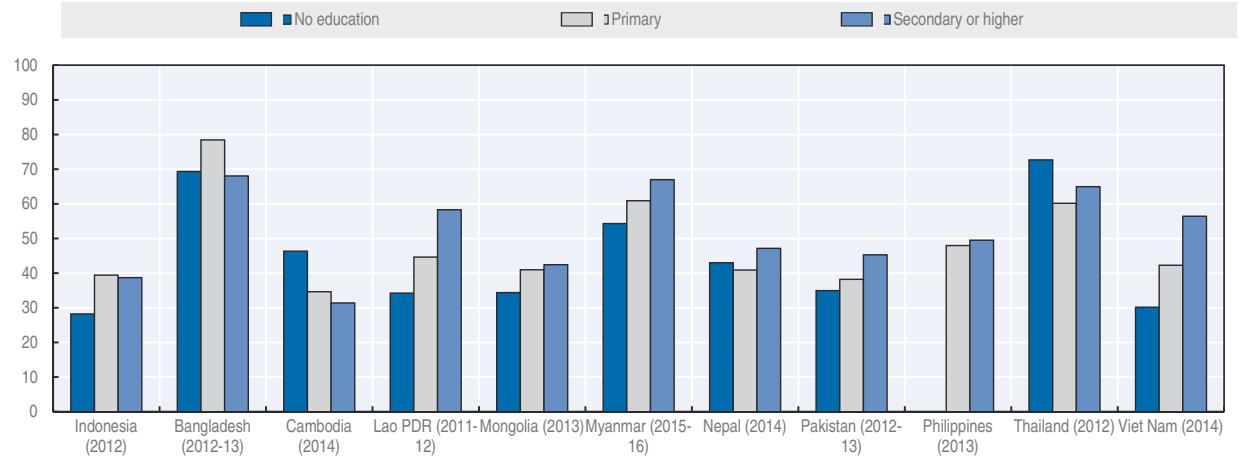
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866847

In Bangladesh, Myanmar and Thailand more than one child in two with diarrhoea receives oral rehydration salts across all education groups, and disparities are small (Figure 2.21). However, in Viet Nam children with diarrhoea whose mother has a higher level of education have two times higher access to treatment as compared to children whose mother has no education. A similar disparity in access is reported for Lao PDR.

Mongolia, the Philippines, Thailand and Viet Nam showed an increase in the use of oral rehydration salts for children with diarrhoea across all education groups over time (Figure 2.22). The divide between more educated women and women with no education in access to oral rehydration for their children with diarrhoea increased in Indonesia and Pakistan over time.

Figure 2.21. **Children aged under 5 years with diarrhoea receiving oral rehydration salts, by mother's education level**



Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866866

Figure 2.22. **Change in the proportion of children aged under 5 years with diarrhoea receiving oral rehydration salts, by mother's education level**

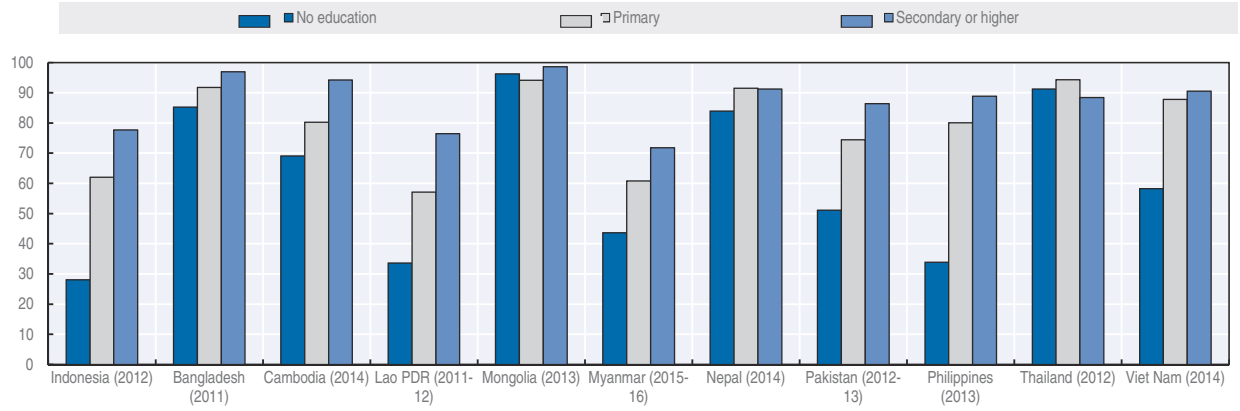
Source: DHS and MICS surveys, various years.

StatLink http://dx.doi.org/10.1787/888933866885

In countries such as Indonesia, Lao PDR and the Philippines inequalities in the proportion of children with immunisation coverage whose mother has high education compared to no education are large with a difference of more than 50% (Figure 2.23).

All reporting countries showed an increase in DTP3 immunisation coverage among one-year old children for all education groups over time, except in Thailand (all education groups) and children whose mother has no education in the Philippines (Figure 2.24). The divide in access to DTP3 immunisation coverage between children whose mother has no education and children whose mother has a higher level of education was large and increasing over time in Indonesia, Lao PDR and the Philippines.

Figure 2.23. **DTP3 immunisation coverage among one-year old children, by mother's education level**



Source: DHS and MICS surveys, various years.

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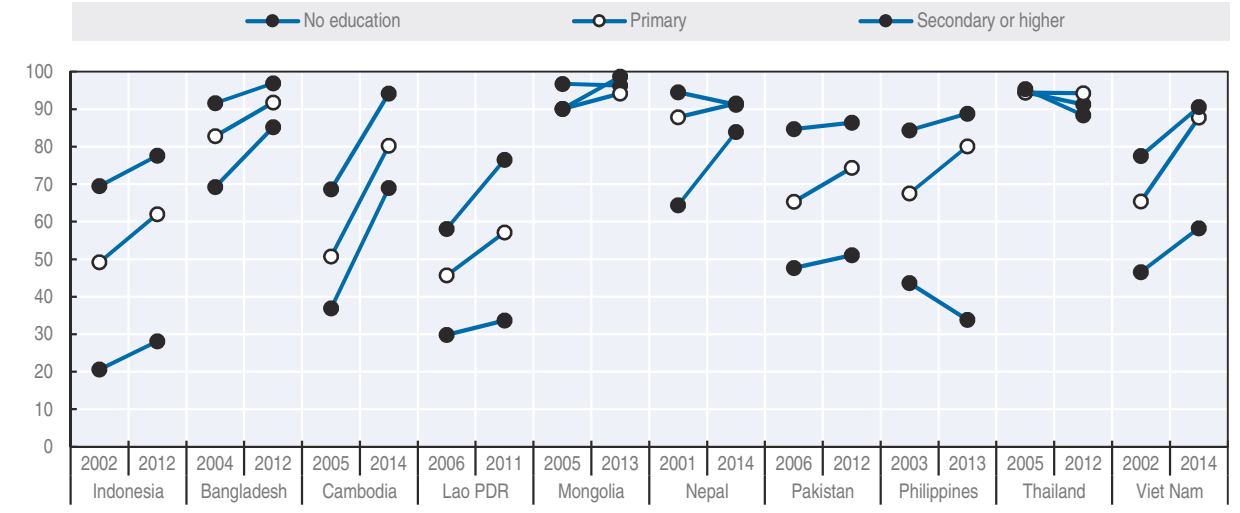
Figure 2.24. **Change in the proportion of DTP3 immunisation coverage among one-year old children, by mother's education level**



Source: DHS and MICS surveys, various years.

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