

Editorial

Refocusing on what matters: Equity in access to quality healthcare services

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Health equity has become a priority agenda for the Sustainable Development Goals (SDGs) across all countries (1). However, as research focused on examining inequalities in coverage of health services, not much is known about inequalities in access to quality health services (2). In part, this could be due to the difficulty of measuring the quality of care because it is complex and requires examining its multidimensional constructs. It could also be because many countries are not providing sufficient health services, and when coverage is lacking, quality is often not a priority. Many countries have dealt with the coverage problem over the years, not 100% still, but the availability of health services has significantly improved. Disparities in access to healthcare services persist across low- and middle-income countries (LMICs), despite significant advances in healthcare coverage over the last few decades (3). In some countries, coverage has increased significantly while the quality of care has remained low, whereas, in others, both coverage and quality of care remain problematic.

Many people often understand health equity as the ease with which one can access healthcare services. However, access alone is not enough. Studies have shown that even when everyone has equal access to care, the poor, racial and ethnic minority groups, and people with disabilities tend to get lower-quality care (3, 4). This demonstrates how, even with increased and equitable access to services, health improvements can be elusive unless those services are of sufficient quality. This also implies that quality improvement initiatives that focus solely on the general population without addressing racial and ethnic differences may result in unequal quality.

According to a recent study, poor quality healthcare kills 5.7 million people each year in LMICs, making it a greater barrier to lowering mortality rates than lack of access to healthcare, which kills 2.9 million people each year (2). This means that each year, 8.6 million individuals living in LMICs die due to poor-quality healthcare systems. Poor care exposes patients to risk, provides misleading data about healthcare system improvements, and may encourage corrupt and fraudulent behaviour by healthcare stakeholders.

Taking maternal and child health services as an example, coverage expansion in LMICs did not result in the expected progress in maternal and newborn health impact indicators (5). It is widely acknowledged that global measures of maternal and newborn health indicators often capture only contacts with the health system, with little information about the quality of care people received. However, increasing the coverage of contact-based interventions alone is insufficient to reduce maternal, newborn, and child mortality. Increased service coverage accompanied by standard service contents would significantly contribute to the elimination of preventable causes of maternal and child mortality.

Recent studies in Ethiopia and other sub-Saharan African countries have also shown that low-quality care is the only kind of care the majority of people receive. For example, in Ethiopia, studies have found low-quality antenatal care and family planning services (6, 7). The quality of care is even worse for marginalised communities, such as the less educated and those living in rural areas. As such, existing service delivery modalities require rethinking and restructuring to address the quality gap and reach vulnerable populations.

Expanding healthcare coverage without ensuring quality care serves no purpose for those in need other than damaging their trust in the healthcare system. As a result, health systems in LMICs should focus on producing positive impacts by ensuring equitable access to quality health services, adhering to standard care processes, and ensuring a positive user experience. Therefore, health systems should focus on monitoring and addressing gaps in the quality of care by identifying what matters most to people. These include implementing effective coverage as a primary strategy to bridge the quality gap. Effective coverage requires that performance be measured not only by the number of people the health system is able to reach but also by incorporating indicators to monitor the content of care

people receive (2). Moreover, quality improvement initiatives should primarily start in areas with poor access to healthcare services and directly consider the needs and experiences of poor and vulnerable populations.

References

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